

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. FOR STATE REGISTRAR					7 9 1 3 5 2 7										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Joseph ABRAMSON</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>6-16-79</i>					2b. HOUR <i>10:17 M</i>					
3. SEX <i>Male</i>			4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>JUNE 12, 1900</i>			6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>79</i>			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>BALTIMORE, MD.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE COUNTY MD.</i>						
10. CITY OR TOWN OF DEATH <i>RANDALLSTOWN</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>BALTIMORE COUNTY GEN. HOSPITAL</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SELF EMPLOYED</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>DRY GOODS</i>						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS <i>2 BITTERROOT CT. APT. 2B (21117)</i>					
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>OWINGS MILLS</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>LOUIS ABRAMSON</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SARAH KASSEL</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>215-10-3205</i>			17. INFORMANT ADDRESS <i>MRS. ANNA ABRAMSON 2 BITTERROOT CT. (21117)</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE <i>5999 respiratory failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>> 24 hrs</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>a. chronic renal failure 8 years</i>										DUE TO, OR AS A CONSEQUENCE OF (c) <i>obstructive lower respiratory tract disease 10 years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>arteriosclerotic cardiovascular disease</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>5-29-79</i> to <i>6-16-79</i> , that (I) (we) last saw the deceased alive on <i>6/16</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>M S Peksa</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6-16-79</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M S Peksa</i>			22e. ADDRESS <i>Balt City Gen Hosp</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>6/17/79</i>			23c. NAME OF CEMETERY OR CREMATORY <i>HEBREW YOUNG MENS</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>WOODLAWN, MD.</i>						
24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON & BROS</i>			6010 Reisterstown rd. <i>BALTIMORE, MD. (21215)</i>			25a. DATE REC'D. BY REGISTRAR <i>JUN 19 1979</i>			25b. REGISTRAR'S SIGNATURE <i>Barney K...</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH-16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ARETHIA ACHENBACH			2a. DATE OF DEATH MONTH DAY YEAR JUNE 15, 1979			2b. HOUR P 5:59 AM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 13 1902		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10 CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Balt., Md. 21214 3109 Juneau Place	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl L. Boyer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 298-09-4604		17. INFORMANT Daughter:		ADDRESS Balt., Md. 21214 3109 Juneau Place			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT SECONDARY TO ADVANCE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA CONTRIBUTING CAUSE OF DEATH DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from JUNE 3 19 79 , to JUNE 15 19 79 , that (if (we) lost saw the deceased alive on JUNE 15 19 79 and that in our opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death.									
22b. SIGNATURE <i>Beatriz P. Dizon</i> M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED June 15, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEATRIZ P. DIZON M.D.				22e. ADDRESS 7620 YORK RD. 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jun 19 1979		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Linton Indiana			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE <i>Beatriz P. Dizon</i>	

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JUNE 12, 1973

ACCOMMODATION

AMERICA

DATE: MAY 17, 1973

TIME

LOCATION

BALTIMORE COUNTY

NAME

AGE

SEX

ST. JOSEPH HOSPITAL

ADDRESS

2100 BALTIMORE

DEPARTMENT

PHYSICIAN

REPORT

DATE

TIME

LOCATION

ALL INFORMATION

IS TO BE

CONFIDENTIAL

EXCEPT

DETERMINATION OF ACCIDENT SCENARIO
TO ELUCIDATE AN ENDOGENOUS CARDIOVASCULAR DYSRHYTHMIA
EXHIBITING CONTRIBUTING CAUSE OF DEATH

JUNE 12, 1973

JUNE 13

JUNE 14

1000 YORK RD. 21004

HEATHER P. DIXON, M.D.

1000

1000

1000

1000

1000

1000

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		7		1 3 5 2 9		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) HORACE R. ADAMS				2a. DATE OF DEATH MONTH DAY YEAR 6-13-79		2b. HOUR 4:30A			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 11, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Timonium		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2428XE 2427 Chetwood Circle	
14. FATHER'S NAME FIRST MIDDLE LAST William Adams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Austin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-1788		17. INFORMANT ADDRESS Ann W. Adams Same as #13.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> <u>1917</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>BRAIN STEM CA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 MONTHS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) (this hospital) attended the deceased from <u>5-31</u> <u>19</u> <u>79</u> , to <u>6-13</u> <u>19</u> <u>79</u> , that (i) (we) lost <u>saw</u> the deceased alive on <u>6-13</u> <u>19</u> <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>				DEGREE <i>B.S.C.H.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 6-13-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.V.M.C. BOOTH				22e. ADDRESS GBMC-6701 N. CHARLES ST.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 15, 1979		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Balto., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, MD. 21204				25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



DHMM-16 20M
(VRA 15, 4) 7/78

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MAGDALENA E. ALBRIGHT			2a. DATE OF DEATH MONTH DAY YEAR JUNE 25, 1979		2b. HOUR 2:22 a.m.	
3. SEX F.	4. RACE W.	5. DATE OF BIRTH MONTH DAY YEAR 2 20 1887	6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Co.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaking	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Sweet-Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Trapp		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Burk		13e. STREET ADDRESS 4725 Sweet Air Rd. Baldwin, Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-42-5524A		17. INFORMANT ADDRESS Baldwin, Md. 21013 Mr. Morris Albright, 4725 Sweet Air Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Pleural effusion DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 17, 1979, to June 25, 1979, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on June 25, 1979, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.						
22b. SIGNATURE Lester A. Wall, Jr., M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED June 25, 1979
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lester A. Wall, Jr., M.D.				22e. ADDRESS 7620 York Road, Towson, MD 21204		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-27-1979		23c. NAME OF CEMETERY OR CREMATORY St. Johns Luth. Ch. Cem.		23d. LOCATION COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME C.F. Lassahn F.N. 11750 BALTIMORE				25a. DATE REC'D. BY REGISTRAR JUN 28 1979		
				25b. REGISTRAR'S SIGNATURE Hocking McCready		

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1. FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN J. ALFIN						2a DATE OF DEATH MONTH DAY YEAR 06 03 79		2b HOUR 4:17PM	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 4 20 24		6 AGE (IN YEARS LAST BIRTHDAY) YRS 55		7a IF UNDER 1 YEAR MONTHS DAYS 7b IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY, MD.			
10 CITY OR TOWN OF DEATH TOWSON, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) G.B.M.C.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b KIND OF BUSINESS OR INDUSTRY Metal Reclam.	
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Glen Arm		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 4202 Antique Lane	
14 FATHER'S NAME FIRST MIDDLE LAST Julius Alfin				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Haimowitz					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17 INFORMANT Mrs. Patricia L. Alfin		ADDRESS Same as # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 410 - Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Myocardial infarction (c) Coronary artery disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 6-4-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. JAMES RICELY, M.D.				22e ADDRESS 6701 N. CHARLES ST. TOWSON, MD. 21204					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6/5/79		23c NAME OF CEMETERY OR CREMATORY Balto. Hebrew Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Randallstown Maryland			
24 FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				ADDRESS 1050 York Road		25a DATE REC'D. BY REGISTRAR JUN 6 1979		25b REGISTRAR'S SIGNATURE [Signature]	

BP

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ALFIM

J.

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WHITE

WALE

BALTO. COUNTY,

TOWSON, MD. G.B.M.C.

X

2-4-79

X

6701 N. CHARLES ST. TOWSON, MD. 21204

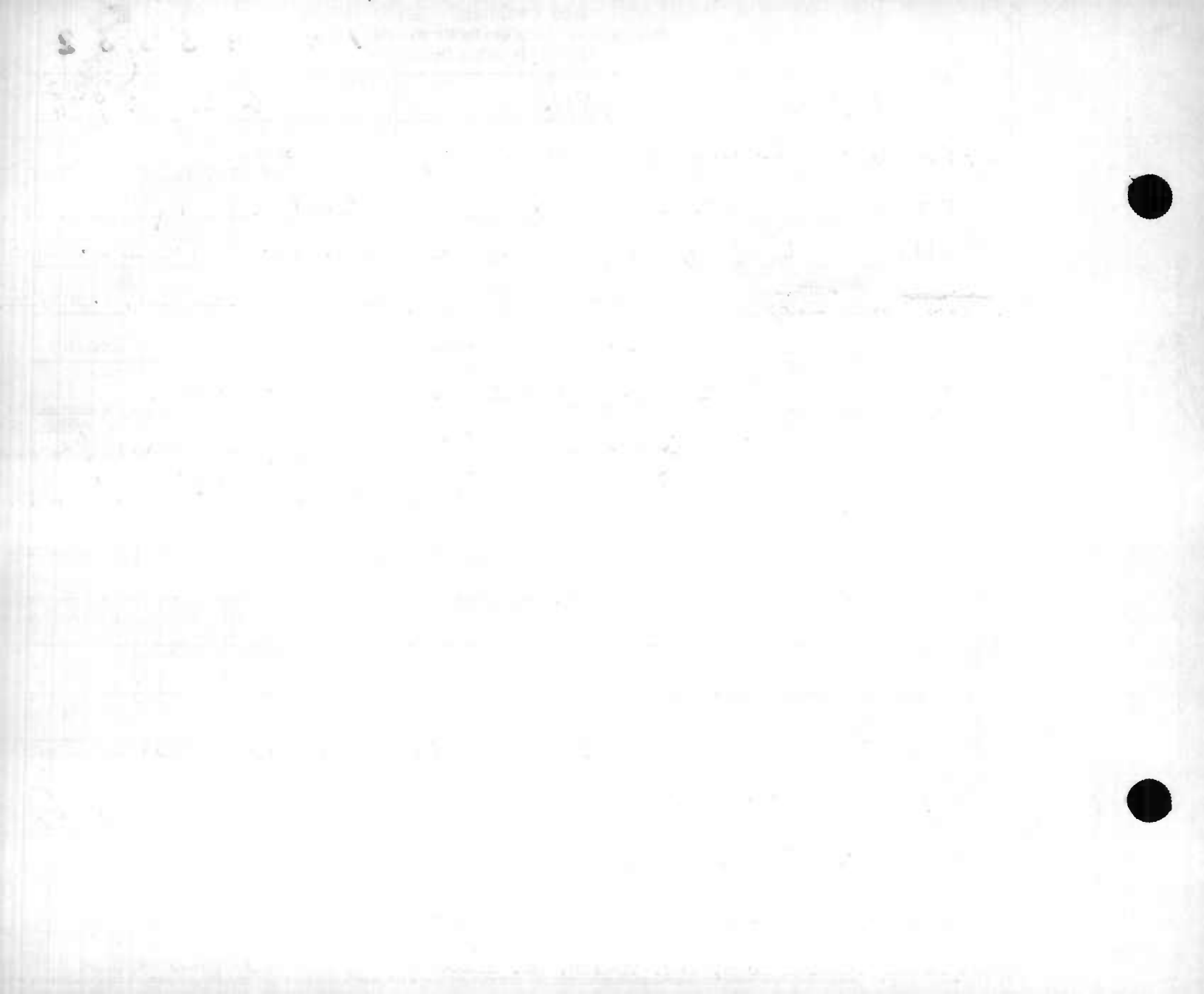
DR. JAMES RICELY, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 3 5 3 2		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Estella H. Allen				2a. DATE OF DEATH MONTH DAY YEAR 6 22 79		2b. HOUR 9 42 a.m.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 9 94		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt County MD.			
10. CITY OR TOWN OF DEATH Balt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Valley View Hsg Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assb. Lime		12b. KIND OF BUSINESS OR INDUSTRY Black & Decker			
13a. STATE OF RESIDENCE Pennsylvania		13b. CITY OR TOWN Fawn Grove		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2639 Jolly Acres Road, Pennsylvania			
14. FATHER'S NAME FIRST MIDDLE LAST George L. Thompson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah S. Jones		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-24-9173		17. INFORMANT ADDRESS William W. Allen, Same As #13d E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe CHF 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH none									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5-29-79, 19-79, to 6-22-79, 19-79, that (I) (we) lost saw the deceased alive on 19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gracita V. Patricia		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/23/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gracita V. Patricia		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-25-79		23c. NAME OF CEMETERY OR CREMATORY Jessops Methodist Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sparks, Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUN 26 1979		25b. REGISTRAR'S SIGNATURE Rickey McCreedy			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERTRUDE E. ALT					2a. DATE OF DEATH MONTH DAY YEAR JUNE 28, 1979			2b. HOUR 2:10 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 22, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baby Sitter		12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN 21204					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1625 Glen Keith Blvd.		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Alt, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Foster					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-03-5843		17. INFORMANT ADDRESS Dorothy L. Warfield 1637 Cottage La.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aortic aneurysm</u> 4416 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unk</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertension, Carcinoma of colon</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I (or this hospital) attended the deceased from <u>6/26/79</u> 19 <u>79</u> , to <u>6/28/79</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/28</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>W. E. Johnson</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/28/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HABERSAS				22e. ADDRESS 16918 YORK RD, MONRTON, MD 21111					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/2/79		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME William E. Johnson 8521 Loch Raven Bd.				25a. DATE REC'D. BY REGISTRAR JUL 2 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony R. Brady</u>			

BP _____

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RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

(14)

Female	White	Dec. 22, 1904	25
Maryland	U.S.A.		
Maryland	Baltimore	1025 Glen Keith Blvd.	
Charles	Alf, St.	Posters	
No	-----	200-03-5003 Dorothy A. Merrill 1025 Cottage La.	

William E. Johnson 6521 Loch Haven Rd.
7/2/70 London Ark. Gov. Baltimore, Maryland

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9

1 3 5 3 4

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Ruth C Argenbright			2a DATE OF DEATH MONTH DAY YEAR June 9 1979			2b HOUR 5:30 P M			
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR JAN 1 1895		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. CO MD.			
10 CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) 3209 Willoughby Rd			12a USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) Housekeeper		12b KIND OF BUSINESS OR INDUSTRY At Home		
13a STATE MD 13b COUNTY BALTO 13c CITY OR TOWN Parkville			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 3209 Willoughby Rd				
14 FATHER'S NAME FIRST MIDDLE LAST John Crawford			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Yingling						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 212-05-8845		17 INFORMANT ADDRESS MARIE ALBRECHT - Same				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Jejunal carcinoma with 1521 DUE TO, OR AS A CONSEQUENCE OF metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 19 54 to June 4 19 79 , that (I) (we) last saw the deceased alive on May 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death, write the body after death.)									
22b SIGNATURE Seymour H. Rubin				DEGREE		22c. DATE SIGNED 6/11/79		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Seymour H. Rubin M.D.				22e ADDRESS 7111 Park Heights Ave					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/12/79		23c. NAME OF CEMETERY OR CREMATORY MT. View		23d. LOCATION CITY OR TOWN COUNTY STATE Clifton Forge Allegheny VA			
24. FUNERAL DIRECTOR NAME EVANS FUNERAL Chapel ADDRESS 8800 Harford Rd				25a. DATE REC'D. BY REGISTRAR JUN 15 1979		25b. REGISTRAR'S SIGNATURE Anthony McCrady			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		REG. NO. 7 1 3 5 3 5											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
JOYCE		M		ARNOLD				6 18 79		M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN			
FEMALE		WHITE		7 10 31		47							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				BALTIMORE COUNTY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		ST. JOSEPH HOSPITAL						Clerk		Social Security			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		352 E. Belvedere Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Raymond H. Arnold										Cora Ditty			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		212-28-5535		Mrs. Cora Arnold		352 E. Belvedere Avenue							
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Right Lung with</u> <u>Mediastinal metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
1978		Resection for purpose of		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE						22c. DATE SIGNED					
Jope T. Villa Jr.		M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						6/19/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
LOPE T. VILLA		SR- 7401 OSLER DRIVE BALTO.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		6-21-1979		Parkwood		Baltimore		Maryland					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.						JUN 20 1979							



STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

 FOR
 1. STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles G Ashley			2a. DATE OF DEATH MONTH DAY YEAR 6 27 79			2b. HOUR 12.40 AM	
3. SEX M	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 10 05 13	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Baltimore Co.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Welding Sup.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Woodlawn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 22 Summerfield Rd. 21207		
14. FATHER'S NAME FIRST MIDDLE LAST William S. Ashley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly Wilmes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Dorothy M. Ashley 22 Summerfield Rd. 21207			

 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
 PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1579

DUE TO, OR AS A CONSEQUENCE OF

 Conditions, if any, which
 gave rise to immediate
 cause (a), stating the
 underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

30 days

25 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION June 2, 79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Poor.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 27, 19 79, to June 27, 19 79, that (I) (we) last saw the deceased alive on June 27, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. R. Young, M.D.						22c. DATE SIGNED June 27, 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Young, J. R.						22e. ADDRESS Baltimore County General Hospital	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6-29-79	23c. NAME OF CEMETERY OR CREMATORY Lorraine Pk. Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME Stanley Funeral		25a. DATE REC'D. BY REGISTRAR JUL 5 1979	
25b. REGISTRAR'S SIGNATURE P. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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THE UNIVERSITY OF MICHIGAN

Robertson, David 1874

High top boots

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE MEDICAL EXAMINER. THE MEDICAL EXAMINER SHOULD SIGN AND DATE PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESIDENT STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 ME (5))
15M 7/76

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 3 5 3 7

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR					
RUTH		C.		AUER				6		9		19		79		545		M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
FEMALE		WHITE		07 03 05		73 YRS.		MONTHS		DAYS		HOURS		MIN.		6		9		19 79 47			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
MARYLAND				U.S.A.				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				BALT. COUNTY											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
HALETHORPE				5730 MINERAL AVENUE, 21227				CLERK				U.S. POST											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
3a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS				OFFICE			
MARYLAND				BALTIMORE				HALETHORPE				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				5730 MINERAL AVENUE, 21227							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
HARRY				LAURA				NO				216-01-7307				FLORIAN J. AUER, 5730 MINERAL AVENUE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION																		MINUTES					
410 - DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) ARTERIOSCLEROTIC HEART DISEASE																		YRS					
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?							
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN				COUNTY				STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED											
David C. Donovan				M.D. Sept								MEDICAL EXAMINER				6/9/79							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
DAVID C. DONOVAN				BON SECOURS HOSP. BALT. MD																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY				STATE			
BURIAL				06-13-79				NEW CATHEDRAL				BALTIMORE CITY				MARYLAND							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
HUBBARD FUNERAL HOME, INC.,				4107 WILKENS AVE.				JUN 11 1979				[Signature]											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 3 5 3 8

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		P M	
Lottie P. AUVIL		June 20, 1979		7:00 P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	81 YRS	MONTHS	DAYS
4/11/1898					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
W. Virginia	U.S.A.		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Dundalk	30 Midship Rd.		HOUSEWIFE		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland		Balto.	Dundalk	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	30 Midship Rd. 21222
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Seymour Wilmoth		Jerusha A. Duckworth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212.14.3176		Hubert B. Auvil--Same as 13e	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4340 Cerebral thrombosis					2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Dec 19 58, to June 20 19 79, that (I) (we) last saw the deceased alive on 6-6-19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Wyman K. Wong, M.D.				6/22/1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
		6730 Holabird Ave., Dundalk, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		6/23/1979	Moreland Mem. Pk.	Baltimore Md.	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Walter Brooks Bradley Inc., Dundalk, Md.			JUN 25 1979		

BP

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OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315



BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												1 3 5 3 9 REG. NO.			
FOR 1- STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT) JAMES WESLEY BAILEY										2a. DATE KNOWN OF DEATH MATED <u>June 6 1979</u>		2b. HOUR 11:18 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 27, 1908		6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD <u>June 6 1979</u>		2d. HOUR 12:28 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD			
10. CITY OR TOWN OF DEATH RODGERS FORGE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 208 OVERBROOK RD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC				12b. KIND OF BUSINESS OR INDUSTRY RAILROAD			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN RODGERS FORGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 208 OVERBROOK RD.					
14. FATHER'S NAME FIRST MIDDLE LAST JAMES IRVIN BAILEY						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY KATHERINE HULLMAN									
16a. WAS DECEASED EVER (YES, NO, OR UNKNOWN) NO				IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 705-03-5347		17. INFORMANT ADDRESS MRS. MAE BAILEY-WIFE SAME							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410 - Sudden ASVD with</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>Acute Myocardial Infarct Sudden</u> (b) <u>Due to, or as a consequence of</u> (c) <u>Due to, or as a consequence of</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				TITLE (SPECIFY) M.D. <u>Deputy</u>				MEDICAL EXAMINER				DATE SIGNED <u>6/6/79</u>			
EXAMINER'S NAME (TYPE OR PRINT) CHARLES F. O'DONNELL M.D.				ADDRESS 7501 YORK RD. TOWSON, MD. 21204											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE JUNE 9, 1979		23c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL				23d. LOCATION CITY OR TOWN YORK, YORK COUNTY PENNA.					
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC. BALTO., MD.				ADDRESS 6500 YORK RD.				25a. DATE REC'D. BY REGISTRAR JUN 11 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



JAMES HENRY GALEY

DATE: APR 21, 1968

ADDRESS: 308 WINDYBROOK BL.

CITY: BIRMINGHAM

STATE: ALABAMA

ZIP: 35202

ORDER NO. 100-100000

DATE: APR 21, 1968

TIME: 10:00 AM

BY: JAMES HENRY GALEY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7. 9		13540		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
HARRY H. BALL								JUNE 16, 1979		9 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		8. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		1-29-1905		74 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON		SAINT JOSEPH HOSPITAL								MARTIN MARTIN	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
MARYLAND		BALTIMORE		PARKVILLE				2803 GLAVIN WAY			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
DANIEL				BALL				JULIA WICK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
NO				220-18-3865		FAMILY RECORDS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CARDIAC ARREST											
411- DUE TO, OR AS A CONSEQUENCE OF PROBABLE CORONARY ARTERY INSUFFICIENCY											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
SHOCK DUE TO RUPTURED AORTIC ANEURYSM											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
JUNE 16, 1979		RUPTURED AORTIC ANEURYSM				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) (this hospital) attended the deceased from JUNE 16, 1979, to JUNE 16, 1979, that (X) (we) lost the deceased alive on JUNE 16, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
						6/17/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
REYNALDO ORJUELA-GOMEZ, M.D.				7620 YORK ROAD, BALTIMORE, MARYLAND 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		6-20-79		MORELAND MEM. PARK		PARKVILLE BALTO. MD.					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
C. F. EVANS & SON, 8802 Harford Rd.				JUN 21 1979				L. J. McBratney			

BP

DHMH-16 20M
(VRA 15, 4) 7/78

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician or, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 3 5 4 1

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	a
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST				
George		FREDERICK		BANGERT				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White	MONTH DAY YEAR June 12, 1895		83 YRS		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.				Baltimore County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rossville	Franklin Square Hospital		Panzer Packing Co.		Self-Employed			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland			Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3625 Frankford Ave.		21214	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST		FIRST MIDDLE LAST						
George		Bant		Anna Marie Kress				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
NO		218-32-3664		Mrs. Myrtle L. Bangert		Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		abdominal sepsis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
5772		Cardio-respiratory arrest, possible intra-						
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		b) Infected pseudo cyst of pancreas						
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/17/19 79, to 6/7/19 79, that (I) (we) lost saw the deceased alive on 6/7/19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED		
						6-7-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
Musa Hindi, M.D.		9000 Franklin Square Drive						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		June 11, 1979		Parkwood		Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck, Inc.		Balto, Md.		JUN 8 1979		R. J. Ruck		

1. 2. 3. 4. 5.

4250

Results

492-515

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 3 5 4 2		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Delia Ethel Barnett			Barnett			June 8, 1979				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		June 13, 1904		74 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Tennessee		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Edgemere		8011 Shore Rd				Housewife					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8011 Shore Rd			
Maryland		Baltimore		Edgemere							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Sherman Kegley				Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
No		228-03-1412		Mr Conley E Bledsoe				Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC Arrest</u> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONSEQUENCE OF Coronary Artery Disease</u> (c) <u>Arteriosclerosis - Diabetes mellitus</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> , 19 <u>65</u> , to <u>April 30</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>April 30</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATES SIGNED					
<u>Marcos Levin MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				6/9/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Marcos Levin, MD.				201 Wise Avenue, Baltimore, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		6/11/79		Holly Hill		Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Duda-Ruck, Inc., Baltimore, Maryland						JUN 12 1979		<u>Jeffrey McCreedy</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

13543

1. DECEASED-NAME (Type or print) GERTRUDE R. BARNICKOL			2a. DATE OF DEATH Month 5 Day 3 Year 79			2b. HOUR 6:03 AM						
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 2/12/1904		6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Ellicott City		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.						
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AUGSBURG 6811 CAMPFIELD RD.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CASHIER				12b. KIND OF BUSINESS OR INDUSTRY DMV				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 6811 CAMPFIELD Rd.				
14. FATHER'S NAME First Middle Last William W. Rhine			15. MOTHER'S MAIDEN NAME First Middle Last Radcliffe									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown			16b. SOCIAL SECURITY NO. 220-16-3063		17. INFORMANT Rev. F.P. DUFF			Address 6811 Campfield Rd. BALTO. MD 21201				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction												
(c) Angina Pectoris, AscVD.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 2-10- , 19 72 , to 5-3 , 19 79 , that (I) (we) last saw the deceased alive on 5/3/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Abdul G. Bureshi M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 5-3-79			
22d. PHYSICIAN'S NAME (Type) ABDUL G. BURESHI						22e. ADDRESS 5010-YORK ROAD, BALTIMORE, MD 21201						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 5, 1979		23c. NAME OF CEMETERY OR CREMATORY St Johns			23d. LOCATION (City or Town) (County) (State) Ellicott City Maryland					
24. FUNERAL DIRECTOR Harry H. Witzke Columbia R.						ADDRESS Ellicott City Md.			25a. REC'D BY REGISTRAR DATE MAY 9 1979		25b. REGISTRAR'S SIGNATURE Barney McCreedy	

1945



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 9 13544							
1. DECEASED NAME (TYPE OR PRINT) MARGARET E BAUER					2a. DATE OF DEATH MONTH DAY YEAR JUNE 18/1979			2b. HOUR 10:55P	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR MAY 2, 1893		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SAINT JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN TOWSON		13e. STREET ADDRESS 820 STONELEIGH RD.			
14. FATHER'S NAME FIRST MIDDLE LAST FRANK SAUER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-32-8589A		17. INFORMANT ADDRESS MARGARET C. BROWN 820 STONLEIGH RD. 21212					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: CARCINOMA OF THE COLON									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 1539 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) RENAL FAILURE, RHEUMATIC HEART DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) this hospital attended the deceased from June 16, 1979 to June 18, 1979 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 18, 1979 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.									
22b. SIGNATURE H. Escalante		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 6/18/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AGATON H. ESCALANTE M.D.				22e. ADDRESS ST. JOSEPH HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 22, 1979		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		23d. LOCATION CITY OR TOWN BALTIMORE COUNTY STATE MD.			
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME				ADDRESS 6500 YORK RD.		25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE Henry McCready	

M

MARGARET E. FAIRBANKS
JUNE 12, 1907

BALTIMORE COUNTY

BALTIMORE HOSPITAL

RECORDS

CARCINOMA OF THE COLON

RENAL FAILURE, PNEUMATIC HEART DISEASE

X

JUNE 18, 1907

JUNE 18, 1907

JUNE 18, 1907



FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 1 3 5 4 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL M. BAUM			2a. DATE OF DEATH MONTH DAY YEAR JUNE 3, 1979		2b. HOUR 4:50
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB. 15, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NEVER WORKED		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM T. ELY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA ROTH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-10-3665D		17. INFORMANT ADDRESS CARLYON W.B. COMMAND 4510 FOREST VIEW AVE. 21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBROVASCULAR THROMBOSIS AND STROKE 4340 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from MAY 8 , 19 79 , to JUNE 3 , 19 79 , that (we) lost saw the deceased alive on JUNE 3 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (did not) view the body after death.					
22b. SIGNATURE A.M. Ghiladi, M.D.		DEGREE		22c. DATE SIGNED 6-3-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.M. GHILADI, M.D.		22e. ADDRESS 7620 YORK ROAD, TOWSON, MARYLAND 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 6, 1979		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEM.	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.		24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME 6500 YORK RD.		25a. DATE REC'D. BY REGISTRAR JUN 8 1979	
		25b. REGISTRAR'S SIGNATURE Barbara McCurdy			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) HELEN BAUM					2a. DATE OF DEATH MONTH DAY YEAR 6-17-79 2b. HOUR 10¹⁵ PM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 27, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OF BIRTH PIKESVILLE BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PIKESVILLE NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS APT. D 6528 PARK HTS. AVE. #21215	
14. FATHER'S NAME FIRST MIDDLE LAST MAX LEVIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-32-3438		17. INFORMANT KENNETH BAUM ADDRESS 2025 W. ROGERS AVE. BALTO., MD 21209					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 436- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CVA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos 2 min									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes mellitus severe decompensated									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 4/26 1979 to 6/17 1979 , that (2) (we) lost view of the deceased about 6/15 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE [Signature] DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/18/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. STUART ROSS				22e. ADDRESS 10219 S. DOLFIELD RD. OWINGS MILLS, MD #21117					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 19, 1979		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR JUN 22 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13547

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARION HENRY BENNER		2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 6 8 1979		2b. HOUR 10²⁶ PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 6 DAY 9 YEAR 05	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance
13a. STATE Md		13b. COUNTY Balls	13c. CITY OR TOWN Eastview	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST Charles MIDDLE BENNER LAST BENNER		15. MOTHER'S MAIDEN NAME FIRST Annie C. MIDDLE Lofton LAST Lofton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 21301 1499		17. INFORMANT Marian C. Benner
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 Other oselotie Cerebrovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE John C. Hylle		TITLE (SPECIFY) Dpty		DATE SIGNED 6-8-79
EXAMINER'S NAME (TYPE OR PRINT) JOHN C. HYLLE		ADDRESS 757 Belair Rd Baltimore 21236 Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6-12-79	23c. NAME OF CEMETERY Greenwood	23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE	25a. DATE REC'D. BY REGISTRAR JUN 12 1979
24. FUNERAL DIRECTOR NAME Philip E. Cook ADDRESS 1211 Chesaco Ave.		25b. REGISTRAR'S SIGNATURE Jeffrey M. Hylle		

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WHITE X

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100% COTTON

BP_____

DHMH - 17
(VR A15 ME (5))
15M7/77

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				1 3 5 4 8 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) THOMASINA MAZIE BERENGER						2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN. June 19 87	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 11 DAY 06 YEAR 1903		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Homemaking							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						13e. STREET ADDRESS 9 Village Green	
14. FATHER'S NAME FIRST Anthony MIDDLE Pistorio LAST Rose				15. MOTHER'S MAIDEN NAME FIRST Rose MIDDLE LAST 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-16-6778		17. INFORMANT Mrs. Carol L. Brown ADDRESS 4328 SilverSpring	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Rt Hip DUE TO, OR AS A CONSEQUENCE OF (b) AS CAUSE DUE TO, OR AS A CONSEQUENCE OF (c) 						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 5 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fractured Rt Hip							
19a. DATE OF OPERATION 6/12/79				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fractured Rt Hip			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. June 1979		21c. HOW INJURY OCCURRED (GIVE NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell in Room			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Nursing Home		21f. LOCATION STREET Engle Rd CITY OR TOWN Parkville COUNTY Baltimore STATE Md			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell				TITLE (SPECIFY) M.D. Deputy		DATE SIGNED 6/12/79	
EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell				ADDRESS 7501 York Road			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/14/79		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery		23d. LOCATION CITY OR TOWN Middle River COUNTY Baltimore STATE Md.	
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home ADDRESS 7401 Belair Road				25a. DATE REC'D. BY REGISTRAR JUN 15 1979		25b. REGISTRAR'S SIGNATURE L. J. McCready	

UNITED STATES

DEPARTMENT OF THE ARMY

WASHINGTON, D. C.

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THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

Item 6 8533 7/10/79 gj

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1 - STATE
REGISTRAR

REG. NO.

7 9 1 3 5 4 9

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jack Stephen BERGMAN, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 6 22 79		2b. HOUR 10:24 M
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12 24 29		6. AGE (IN YEARS LAST BIRTHDAY) 49 45 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH ESSEX	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POLICE		12b. KIND OF BUSINESS OR INDUSTRY —
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD.	13b. COUNTY BALTO	13c. CITY OR TOWN ESSEX	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1515 NICOLAY RD.	
14. FATHER'S NAME FIRST MIDDLE LAST MERTON BERGMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH DAVIDSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI 220-24-6005	17. INFORMANT ADDRESS BETTY LOUISE BERGMAN ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest. 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Metastatic Bronchogenic Carcinoma (c) Due to, OR AS A CONSEQUENCE OF, with lymph node, liver and ? GI metastasis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/22/19 79, to 6/22/19 79, that (I) (we) last saw the deceased alive on 6/22/19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Salem E. Khaneja M.D.		DEGREE M.D.		22c. DATE SIGNED 6/22/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Satish Khaneja, M.D.		22e. ADDRESS 9000 Franklin Square Drive			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 6/23/79	23c. NAME OF CEMETERY OR CREMATORY LONDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.	
24. FUNERAL DIRECTOR NAME Connelly F.H. 300 Mace ave.		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUN 26 1979	25b. REGISTRAR'S SIGNATURE Rickey McCreedy

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

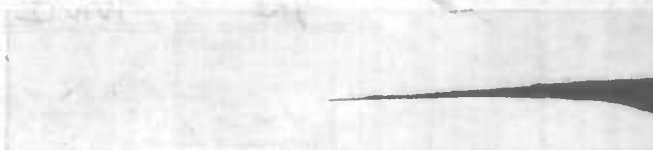
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove entire papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

BALTIMORE, MARYLAND 21201

DIVISION OF VITAL RECORDS, 201 W. PRESTON

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, part of this certificate should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 1 3 5 5 0 REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) EMANUEL		FIRST MIDDLE LAST BERMAN		2a DATE OF DEATH MONTH DAY YEAR MON., JUNE 4, 1979	
3 SEX MALE		4 RACE WHITE		2b HOUR A.M. 2:50	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS LAST BIRTHDAY) 65	
10 CITY OR TOWN OF DEATH LUTHERVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1180 BERANS RD.		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
13a STATE MARYLAND		13b CITY OR TOWN BALTO.		13c STREET ADDRESS 1180 BERANS RD. #21093	
14 FATHER'S NAME FIRST MIDDLE LAST MAX BERMAN		15 MOTHER'S MAIDEN NAME MIDDLE LAST REBECCA UNKNOWN		12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) PROPRIETOR	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. 216-03-8893		17 INFORMANT MRS. MARI BERMAN	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarct, Cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) the hospital attended the deceased from <u>Oct 1963</u> to <u>Sept 26 1978</u> , that (2) I last saw the deceased alive on <u>Sept 26 1978</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated					
22b SIGNATURE <u>Dr. Samuel Tompakov</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 6-4-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. SAMUEL TOMPAKOV		22e ADDRESS 7211 PARK HTS. AVE.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE JUNE 5, 1979		23c NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW	
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215		25a DATE REC'D. BY REGISTRAR JUN 6 1979		25b REGISTRAR'S SIGNATURE <u>P. H. H. H.</u>	

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Confidential Report
Applicant's Information

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

13551

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WELL F. BERRY			2a. DATE OF DEATH MONTH DAY YEAR 6-3-79			2b. HOUR 2:10AM				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-01-84		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. county MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Puxton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physical Therapist		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles C. Berry Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tda May Fink					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-09-4033		17. INFORMANT ADDRESS Pickersgill 615 Chestnut Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF: (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic Cardiovascular Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several Years								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Walter T. Kees					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER T. KEES					22e. ADDRESS 3018 Hooks Mill Rd Monkton Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/5/79		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.					ADDRESS 1050 York Road		25a. DATE REC'D. BY REGISTRAR JUN 6 1979		25b. REGISTRAR'S SIGNATURE L. J. McBrady	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, dog should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 2 3 4 5

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-443883)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [REDACTED]
RE: [REDACTED]

[REDACTED]

Very truly yours,
[REDACTED]
Special Agent in Charge

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 15 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17
(VR A15 ME (5))
15M/7/77

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13552

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR						
LORENE		M.		BEVIER				June 14		1979								9 PM						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD						2d. HOUR						
Female		White		July 11, 1895		83 YRS.		MONTHS		DAYS		HOURS		MIN		June 22, 1979		5 PM						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH												
Maryland				X U. S. A.								Baltimore County												
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY												
Towson				204 E. Joppa Rd.				Homemaker				Own Home												
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																								
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS								
Maryland				Baltimore				Towson				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				204 E. Joppa Road								
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME														
FIRST MIDDLE LAST										FIRST MIDDLE LAST														
Charles William Mc Knew										Juliet May Hale														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS				
NO										UNKNOWN					Eleanor L. Feldmann, Lajolla, Calif.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial</u> 410- } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } gave rise to immediate } cause (a) stating the under- } lying cause lost. } (b) <u>Infarction from ASCVD</u> (c) } PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
																		Sudden						
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?				
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)														
					P.M. 19																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION														
										STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																								
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED				
Chas. E. Donnell, M.D.										J. J. J. J.										6/22/79				
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE									
XXXXXX Cremation					26-79					Loudon Park Crematory					Baltimore, Maryland									
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE				
NAME ADDRESS										Towson, Md. 21204										JUN 26 1979				
Ruck Towson Funeral Home, Inc.										1050 York Rd.														

5 4 3 2 1



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

79

13553

FOR STATE
HEALTH DEPT.

1. DECEASED-NAME (Type or Print) Gregory A. Beyer			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year June 23, 1979			2b. HOUR 4 P.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH Feb. 21, 1929	6. AGE (In years last birthday) 50 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD June 23, 1979		
7a. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Reisterstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 319 Wembley Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Controller		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 319 Wembley Road
14. FATHER'S NAME Frank Beyer			15. MOTHER'S MAIDEN NAME Josephine Zittle					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 216-24-7182		17. INFORMANT ADDRESS Mrs. Betty E. Beyer Reisterstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute M.C. 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Inst.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dr. Lester N. Kolman M. D.		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED June 23, 1979		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 26, 79		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION (City or Town) (County) (State) Finksburg, Md.		
24. FUNERAL DIRECTOR Eline Funeral Home				ADDRESS Reisterstown, Md. 21136		25a. REC'D BY REGISTRAR DATE JUN 25 1979		25b. REGISTRAR'S SIGNATURE L. H. McCreedy

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Pa-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED
FEB 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO: DIRECTOR, U.S. DEPARTMENT OF AGRICULTURE
FROM: [illegible]
SUBJECT: [illegible]



Very truly yours,
[illegible]
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mayford A. Blackburn			2a. DATE OF DEATH MONTH DAY YEAR June 30, 1979			2b. HOUR M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR September 16, 1911		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 67 YRS		7 IF UNDER 1 YEAR IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Villa Nova		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3903 Buckingham Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Iron Molder		12b. KIND OF BUSINESS OR INDUSTRY Flynn & Emir	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Villa Nova		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3903 Buckingham Road	
14 FATHER'S NAME FIRST MIDDLE LAST Aaron Minton Blackburn				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Curry					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17 INFORMANT Mrs. Betty J. Blackburn		ADDRESS 3903 Buckingham Rd 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure & VAC.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yr 5 yr -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>75</u> to <u>June 30</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-8-79</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Bernard Karpers				DEGREE MD				22c. DATE SIGNED 7-3-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Bernard Karpers				22e. ADDRESS 101 W. Reed 513 Medical Arts Building 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE July 3, 1979		23c. NAME OF CEMETERY OR CREMATORY Lake View		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.			
24. FUNERAL DIRECTOR NAME Loring Byers ADDRESS 8728 Liberty Road Randallstown, Maryland				25a. DATE REC'D. BY REGISTRAR JUL 3 1979		25b. REGISTRAR'S SIGNATURE Robert M. Brady			

1881

RECORDS OF THE

(11)



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79 13555

1. FOR REGISTERAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		SARAH R. BLIZZARD		JUNE 89, 1979	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		MONTH DAY YEAR 6 20 34		44 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON		St. Joseph Hospital		Hw			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Carroll		Hampstead		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST Marion A. Miller		FIRST MIDDLE LAST Emily Riley		no		219-28-0534	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLE ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>DISEASE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 6, 1979</u> to <u>JUNE 9, 1979</u> , that (we) lost the deceased alive on <u>JUNE 9, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>Viewed</u> <input checked="" type="checkbox"/> <u>did not view</u> <input type="checkbox"/> the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
						6/9/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
JUNE E RIVERA		50 SCOTT ADAM RD COCKEYSVILLE, MD		Burial		6-13-79	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Mt. Gilead Cemetery		Reisterstown Balto Md.		Eline Funeral Home, Hampstead, Md. 21074		JUN 12 1979	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



10:21P

JUNE 20, 1978

P. MRS. HILZARD

BARAN

10:21P

JUNE 20, 1978

P. MRS. HILZARD

BARAN

10:21P

JUNE 20, 1978

P. MRS. HILZARD

BARAN

10:21P

JUNE 20, 1978

P. MRS. HILZARD

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JUNE 20, 1978

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P. MRS. HILZARD

BARAN

10:21P

JUNE 20, 1978

P. MRS. HILZARD

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P. MRS. HILZARD

BARAN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 3 5 5 6

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN THEUER BOEPPLE			2a. DATE OF DEATH MONTH DAY YEAR June 15, 1979			2b. HOUR 2:35A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 1, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Towson				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister		12b. KIND OF BUSINESS OR INDUSTRY Church	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2121 Westfield Ave.	
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14. FATHER'S NAME FIRST MIDDLE LAST John Boepple		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Theuer	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17. INFORMANT Catherine Boepple		ADDRESS 21214	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Subacute Ischemic Cardiac Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 5915		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5915	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (the hospital) attended the deceased from **August 25, 1979** to **June 19, 1979**, that (I) (we) lost
saw the deceased alive on **15 June 1979**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death.

22b. SIGNATURE Walter T. Kees		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED June 15, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter T. Kees, M.D.				22e. ADDRESS Houcks Mill Rd. - Monkton			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 18, 1979		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto., Md.	
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24. FUNERAL DIRECTOR NAME ADDRESS ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, Md. 21214		25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE Robert C. Altenburg	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR 1 - STATE REGISTRAR		7 9 1 3 5 5 7	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
PEARL E. BOONE		June 23 1979	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
FEMALE	White	April 20 1895	84 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	United States		Baltimore MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A NURSING FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Randalls town	Baltimore County General Hospital	HOMEMAKER	
13a. STATE		13b. COUNTY	13c. STREET ADDRESS
MARYLAND	BALTIMORE	WOODLAWN	5412 LEWELLEN AVENUE, 21207
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
HERBERT		KATE UNKNOWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	
NO		218-50-5682	
17. INFORMANT		ADDRESS	
SILVER CROSS HOME,		5124 GREENWICH AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus, CVA with Right hemiplegia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from June 24 1979, to June 26 1979, that (I) (we) lost saw the deceased alive on June 24 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>McLeod (Proctor)</u>		DEGREE MD	22c. DATE SIGNED 6/23/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) McLeod J. Proctor		22e. ADDRESS 1811 N. Hollins Rd. Woodlawn, Md 21207	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	06-26-79	LORRAINE PARK	WOODLAWN BALTIMORE MD.
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.		JUN 25 1979	History McLeod

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UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF
WASHINGTON, D.C. 20315



Page 2

MEMORANDUM FOR THE CHIEF OF STAFF

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 3 5 5 8

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		June 29, 1979		12:10pM	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Female		White		12 10 23	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Baltimore		USA		9 BALTIMORE CITY OR COUNTY OF DEATH	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
TOWSON		SAINT JOSEPH HOSPITAL		operator	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md		Balto		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS	
Walter Chalek		Stella Moskwa		8008 Remington Avenue	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		217 18 1812		William Borkowski 8008 Remington Avenue	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY.					
IMMEDIATE CAUSE (a) Shock					
1990 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 26, 19 79, to June 29, 19 79, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 29, 19 79, and that it is <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
		June 29, 1979		Sami A. Brahimi, M.D.	
22e. ADDRESS		22f. NAME OF CEMETERY OR CREMATORY		22g. LOCATION CITY OR TOWN COUNTY STATE	
200 E. Lexington St., Baltimore, MD 21201		St Stanislaus		Baltimore, Maryland Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		7/2/79		St Stanislaus	
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Walter Dabrowski		1005 Dundalk Avenue		JUL 6 1979	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Walter Dobrowski

1005 Second Avenue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 3 5 5 9			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Lloyd Abraham Bosch				June 9, 1979								2:24A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		Dec. 9 1906		72		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Penna.		USA				Baltimore County,						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Rossville 21237		Franklin Sq. Hospital		Mechanic		Aircraft							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS							
Md. Baltimore				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		609 N. Stuart Street 21221							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Joseph R. Bosch				Rene M. Meyers									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		172 01 3061		Marshall Bosch		Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomegaly Secondary to Calcific Aortic Stenosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4241 DUE TO, OR AS A CONSEQUENCE OF (b) _____													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 23, 1979</u> , to <u>June 9, 1979</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 9, 1979</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (do not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
<u>David Padrino</u>				M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				6/9/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
David Padrino, M.D.				9000 Franklin Square Drive 21237									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		6/11/79		Mt. Olivet Cemetery		New Cumberland, Pa.							
24. FUNERAL DIRECTOR'S NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Bruzdzinski Funeral Home PA 1407 Old Eastern Ave				JUN 12 1979				<u>David Padrino</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 13560				
1. DECEASED NAME (TYPE OR PRINT) Anne H. Bowen					2a. DATE OF DEATH MONTH DAY YEAR June 16, 1979			2b. HOUR 11:30 M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR May 4, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) College Manor				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Anton Hasenkamp			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Obrecht			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
17. INFORMANT ADDRESS Pikesville, Md.			18a. SOCIAL SECURITY NO. 219 30 6406			18b. CITY OR TOWN Mt. Wilson Ln.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute heart attack 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause: (a) stating the underlying cause last. (b) ASA VD DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1956 P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE June 16 79			
22a. I certify that (I) (this hospital) attended the deceased from June 16 79 to June 16 79 , that (I) (we) last saw the deceased alive on June 16 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If physician did not view the body after death, so state.)									
22b. SIGNATURE William G. Helfrich MD DEGREE					22c. DATE SIGNED 6/18/79			22d. ADDRESS 5006 Roland Ave.	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) William G. Helfrich, M. D.			22f. ADDRESS 5006 Roland Ave.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/18/79		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Md.		
24. FUNERAL DIRECTOR NAME MITCHELL-Wiedefeld Home, Inc. ADDRESS 6500 York Rd.					25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE Robert M. Brady		

13200

June 1, 1957

May 31, 1957

Albany County

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, gray, be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Opal Leone Bowman		2a. DATE OF DEATH MONTH DAY YEAR 6/4/79		2b. HOUR 10⁴ PM	
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR August 12, 04		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. CITY OR TOWN OF DEATH Randallstown		9b. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County Gen. Hosp.		9c. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE West Virginia 13b. COUNTY Grafton 13c. CITY OR TOWN Grafton		11. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		12. STREET ADDRESS 207 Linden Street 26354	
14. FATHER'S NAME FIRST MIDDLE LAST Perry Floyd Gillispie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Sophia Green		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 236-56-4819	
17. INFORMANT Mrs. Norma L. Kraft ADDRESS 21133 9019 Hamor Rd. Randallstown, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Endotoxic Shock DUE TO, OR AS CONSEQUENCE OF (b) Urinary tract infection & septicemia DUE TO, OR AS CONSEQUENCE OF (c) P.O. for carcinoma of rectum & liver metastases		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus					
19a. DATE OF OPERATION 6/7/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA of Rectum		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Marvin M. Nachlas DEGREE M.D.		22c. DATE SIGNED 6/7/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN M. NACHLAS	
22e. ADDRESS 6503 Park Heights Ave.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/7/79	
23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		23d. LOCATION CITY OR TOWN Taylor Cou. COUNTY West Virg STATE MD		24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. NAME 18728 Liberty Road ADDRESS Randallstown, Md. 21133	
25a. DATE REGD. BY REGISTRAR JUN 7 1979		25b. REGISTRAR'S SIGNATURE Loring Byers		25c. REGISTRAR'S NAME Loring Byers	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOUR MIN	
WOODROW H BRADFORD		June 13, 1979		10:45a M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
male	White	MONTH DAY YEAR	57 YRS.	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Rossville	Franklin Square Hospital		Warehouseman		Doxsee Foods
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland		Baltimore	Middle River	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	5 Walkway Court
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		16b. SOCIAL SECURITY NO.	
William Bradford		Elizabeth Griffin		212-16-7645	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		WW II		Mary Bradford 5 Walkway Court	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest; Acute Yellow Atrophy of the Liver</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
570- <u>570-</u> DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Generalized Arteriosclerosis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 31</u> , 19 <u>79</u> , to <u>June 13</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 13</u> , 19 <u>79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above.					22c. DATE SIGNED
22b. SIGNATURE <u>Dr. DelMonte</u> DEGREE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS
Dr. DelMonte					9000 Franklin Square Drive 21237
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		6/16/79	Holly Hill Cemetery	Middle River Balto. Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lassahn Funeral Home		JUN 18 1979		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE REGISTRAR XC 18 962 814

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE ROBERT BRADLEY			2a. DATE OF DEATH MONTH DAY YEAR JUNE 13, 1979		2b. HOUR 7:45 pm
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY 2, 1928	6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A.M.C., FORT HOWARD, MARYLAND		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OFF-SET CAMERAMAN		12b. KIND OF BUSINESS OR INDUSTRY PHOTOGRAPHY
13a. STATE MARYLAND			13b. COUNTY PRINCE GEORGE	13c. CITY OR TOWN GLEN DALE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOHN H BRADLEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA DANIEL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 453000000	17. INFORMANT Rose Bradley ADDRESS same as # 13 CLINICAL RECORDS, VAMC, FORT HOWARD, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MYOCARDIAL INFARCTIONS TIMES THREE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>12/15/77</u> , 19 <u>79</u> , to <u>6/13/79</u> , that (we) lost saw the deceased alive on <u>6/13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A. Mendoza</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/14/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMABLE MENDOZA, M.D.		22e. ADDRESS VAMC, FORT HOWARD, MD 21052			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 15 JUN 79	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland	
24. FUNERAL DIRECTOR NAME BEALL FUNERAL HOME 9013 ANNAPOLIS RD. LANHAM, MD		ADDRESS G. Sullivan		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 19 1979	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1- STATE REGISTRAR					REG. NO. 7 9 1 3 5 6 4				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE W. BRANE					2a. DATE OF DEATH MONTH DAY YEAR 6 6 1979				
3 SEX MALE					2b. HOUR 1:30 P.M.				
4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 8 31 1891			6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10 CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LITTLE SISTERS OF THE POOR			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE ARIZONA		13b. COUNTY		13c. CITY OR TOWN PHOENIX		13e. STREET ADDRESS 1110 NORTH 16TH ST.			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN THOMAS BRANE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARILLA SCOTT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 414-05-9679		17 INFORMANT ADDRESS SR. LORETTO 601 MAIDEN CHOICE LANE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive myocardium infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Parkinson's disease, A.S. cardio</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>vascular disease Diabetes mellitus</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>78</u> to <u>June 6</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>May 17</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stanley Ankudras</u> M.D.					DEGREE M.D.			22c. DATE SIGNED 6-6-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY ANKUDRAS					22e. ADDRESS 1101 Maiden Choice La, Balto M. 21229				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 06-09-79		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.,					ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR JUN 8 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

1900





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4 - 13565

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH										2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) Stephen Y. Bready										MONTH DAY YEAR 6 27 1979										M a			
3. SEX male		4. RACE white		5. DATE OF BIRTH 1/16/51		6. AGE (IN YEARS) 28		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD 6 27 1979										7d. 09	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County										MD.	
10. CITY OR TOWN OF DEATH Brooklandville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Brook Falling Road								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Press Secretary Executive						12b. KIND OF BUSINESS					
13a. STATE Md.										13b. COUNTY Balto.		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1821 Ridgeway Avenue							
14. FATHER'S NAME James H. Bready										15. MOTHER'S MAIDEN NAME Mary Hortop													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 216-56-4820				17. INFORMANT Mrs. Mary Bready Balto., Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY: acute carbon monoxide intoxication																							
IMMEDIATE CAUSE (a) 9520																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b)																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 6 27 1979				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) attached exhaust into rear window															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street				21f. LOCATION Brook Falling Road, Brooklandville, Md.															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE Margaret BeYhall				TITLE (SPECIFY) Assistant										DATE SIGNED 6/27/79									
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6-29-79		23c. NAME OF CEMETERY OR CREMATORY Bellevue				23d. LOCATION Harvard, Mass.													
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co.				ADDRESS 4905 York Road Balto., Md. 21212				25a. DATE REC'D. BY REGISTRAR JUN 29 1979				25b. REGISTRAR'S SIGNATURE											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 13566					
1. DECEASED NAME (TYPE OR PRINT) WILLIAM H BREDLOW					2a. DATE OF DEATH MONTH MAY DAY 21 YEAR 1979			2b. HOUR 3:00 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 9 DAY 17 YEAR 1929		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retail Mgr.		12b. KIND OF BUSINESS OR INDUSTRY Western Auto		
13a. STATE Md.					13b. COUNTY Baltimore		13c. CITY OR TOWN Kingsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST William MIDDLE Bredlow LAST Fuss					15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE Ziegen LAST Fuss					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1950-1953		17. INFORMANT 21087 ADDRESS 1109 Hollingsworth Rd., Kingsville, Md.		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1541 DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (c) CA RECTUM				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from May 5, 1979 to May 21, 1979 , that (we) last saw the deceased alive on May 21, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.										
22b. SIGNATURE Antonio S. Ravida					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-21-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO S. RAVIDA					22e. ADDRESS 7620 YORK RD 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-23-1979		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Overlea Baltimore Md.		25a. DATE RECD. BY REGISTRAR MAY 24 1979		
24. FUNERAL DIRECTOR NAME Kingsville, Md. 21087 Joseph F. 8/11/50					25b. REGISTRAR'S SIGNATURE Joseph F. 8/11/50					

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WILLIAM C. CANNON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					7 9 1 3 5 6 7 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Joseph F. Brennan, Jr.					2a. DATE OF DEATH June 20, 1979			2b. HOUR 7:36 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 8 5 18		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 509 Overcrest Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Manager		12b. KIND OF BUSINESS OR INDUSTRY XXXXX Shaivitz		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Towson					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 509 Overcrest Road			
14. FATHER'S NAME Joseph F. Brennan, Sr.					15. MOTHER'S MAIDEN NAME Garnet Ashton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW11 057-12-5499		17. INFORMANT ADDRESS Georgette A. Brennan, Same As #13e						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Ketoacidosis</u> 2501 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days 15 yrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>NASCVB</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <u>5/79</u> 19____, to <u>6/20/79</u> 19____, that (I) (we) last saw the deceased alive on <u>1/79</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)										
22b. SIGNATURE <u>Paul J. Edgar, M.D.</u>					DEGREE		22c. DATE SIGNED <u>6/29/79</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Edgar, M.D.					22e. ADDRESS 1205 York Road Lutherville, Md. 21093					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-23-79			23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Md.	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. ADDRESS Towson, Md. 21204					25a. DATE REC'D. BY REGISTRAR JUN 22 1979		25b. REGISTRAR'S SIGNATURE <u>Rickey McCreedy</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 202-342-1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 3 5 6 8 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Marie Theresa Briscoe</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>06-12-79</i>		2b. HOUR <i>8:15 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>04-17-96</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Multi Medical Convalescent</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Hornemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md</i>						13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Balto</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert Henry Hicks</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Helen Thomas</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>						16b. SOCIAL SECURITY NO. <i>2B-14-3699T</i>		17. INFORMANT ADDRESS <i>Mr. Hammond Briscoe 2422 W. Lanvale St. Balto., Md.</i>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>Chronic Renal failure, Uremia</i> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b): <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c): APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i> <i>7 yr</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Hypertension, Acinosis (metabolic), Anemia</i>									
19a. DATE OF OPERATION <i>N/A</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>N/A</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>N/A</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>N/A</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>N/A</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>N/A</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>5/26</i> 19 <i>79</i> to <i>6/12</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>6/11</i> 19 <i>79</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death)									
23a. SIGNATURE <i>A. H. Janoski, MD</i>						DEGREE <i>MD</i>		23c. DATE SIGNED <i>6/13/79</i>	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. H. Janoski, MD</i>						23e. ADDRESS <i>2250 Green ST R H Med 2120</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/16/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Chatman Funeral Home</i>						25a. DATE REC'D. BY REGISTRAR <i>JUN 14 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Patricia K. Binkley</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 3 5 6 9 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Otis P Brown					2a. DATE OF DEATH MONTH DAY YEAR 6-4-79			2b. HOUR 7:52 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11/13/1897		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH County - Balto. MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mult. Medical N.Y. York				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conductor		12b. KIND OF BUSINESS OR INDUSTRY B&O R.R.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Brown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Eddy St. John					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-05-7772		17. INFORMANT ADDRESS Beverly Thompson 9709 Conmar Road						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Heart + Aneurysm 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Natural Aging									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4m	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Parkinson's Disease										
19a. DATE OF OPERATION 4/17/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intra-aortic balloon pump				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A N/A						
22a. I certify that (I) (this hospital) attended the deceased from June 3, 1979 to June 4, 1979, that (I) (we) last saw the deceased alive on June 3, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)										
22b. SIGNATURE Alfonso N Janowski MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/4/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alfonso N Janowski, MD					22e. ADDRESS 22 So Greene ST Balto Md 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/6/79		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Olelea Baltimore Md.				
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home					ADDRESS 7401 Belair Road		25a. DATE AND BY REQUEST JUN 7 1979		25b. REQUESTED BY Beverly Thompson	

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Robert" and "James" are faintly visible.]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

13570

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		6/13/79		2:10 a.m.	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Caucasian		6/22/94		84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Baltimore County MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		Greater Baltimore Medical Center		Homemaker		Own Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		314 E. Melrose Avenue			
Walter Johnston		Sallie Anderson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		213-74-3086		Walter E. Brown		Same	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 514- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pulmonary emboli</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>79</u> , to <u>6/13</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/12</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Ronald L. Sirota M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/13/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald L. Sirota, M.D.				22e. ADDRESS 6701 N. Charles St., Balto., MD 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-15-79		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. County, Md.	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212				25a. DATE REC'D. BY REGISTRAR JUN 14 1979		25b. REGISTRAR'S SIGNATURE <u>Henry W. Jenkins</u>	

U 221 13210




 1 - FOR
STATE
REGISTRAR

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

 79 13571
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) STEWART R. BROWN			2a DATE OF DEATH MONTH DAY YEAR JUNE 15, 1979			2b HOUR M 			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR MAY 25 1923		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS 	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10 CITY OR TOWN OF DEATH HAMPSTEAD		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18823 FALLS ROAD				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b KIND OF BUSINESS OR INDUSTRY 	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13b STREET ADDRESS 18823 FALLS ROAD					
13a STATE MD.		13b CITY OR TOWN HAMPSTEAD		13c CITY OR TOWN 		13d STREET ADDRESS 		13e STREET ADDRESS 			
14 FATHER'S NAME FIRST MIDDLE LAST ENSOR BROWN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH KNIGHT			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b SOCIAL SECURITY NO. 217-01-0538A		
17 INFORMANT DAUGHTER			17 ADDRESS 			17 ADDRESS 			17 ADDRESS 		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic 7 2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) 		SPECIFICATE INTERVAL BETWEEN ONSET AND DEATH 	
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION 6/18/79		19b CONDITION FOR WHICH OPERATION WAS PERFORMED 		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f LOCATION STREET CITY OR TOWN COUNTY STATE 			
22a I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE J. ALLAN BALDANZA, M.D.				DEGREE 		22c DATE SIGNED 	
22d PHYSICIAN'S NAME (TYPE OR PRINT) J. ALLAN BALDANZA, M.D.				22e ADDRESS 8 CEDAR KNOLL ROAD			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 6/18/79		23c NAME OF CEMETERY OR CREMATORY POPLAR GROVE		23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE COUNTY MD.	
24 FUNERAL DIRECTOR NAME ADDRESS EVANS FUNERAL CHAPEL 7325 YORK RD				25a DATE REC'D. BY REGISTRAR JUN 19 1979		25b REGISTRAR'S SIGNATURE Henry McCurdy	

TO HOSPITAL OF ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

BP

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1 3 2 7 1



STEWART R. GRIFFIN June 10 1912

WHITE

MARRIAGE

HAMPDEN 1873 FALLS ROAD

M.D. HAMPDEN X 1873 FALLS ROAD

ELIZABETH KNIGHT

DAUGHTER

2 ALLEN ST. DARTMOUTH & GENEVA KNIGHT ROAD

GRACE FARMER CHURCH 1873 FALLS ROAD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9		1 3 5 7 2		REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilfred D. BRYDGES					2a. DATE OF DEATH MONTH DAY YEAR June 21, 1979			2b. HOUR 8:50P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 30, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Night Engineer		12b. KIND OF BUSINESS OR INDUSTRY Maryland Casualty		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Brydges					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Conliffe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 105-05-4280		17. INFORMANT ADDRESS Mrs. Annice R. Ripperger 535 Seneca Park Rd						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5315 IMMEDIATE CAUSE (a) Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Generalized suppurative peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Perforated gastric ulcer									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. certify that X (this hospital) attended the deceased from June 21, 19 79, to June 21, 19 79, that (we) last saw the deceased alive on June 21, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.										
22b. SIGNATURE Oscar Ramirez						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/21/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Oscar Ramirez MD						22e. ADDRESS 9000 Franklin Square Dr. 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-25-1979		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.						25a. DATE REC'D. BY REGISTRAR JUN 26 1979		25b. REGISTRAR'S SIGNATURE Anthony McBrady		

21281



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CAROLINE E. BUCKINGHAM					2a. DATE OF DEATH MONTH DAY YEAR 6 15 1979					2b. HOUR 2 40 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG 2 1892		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS 86		IF UNDER 24 HRS. HOURS MIN. 2 40	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.					
10. CITY OR TOWN OF DEATH 70		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perring Parkway Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK			12b. KIND OF BUSINESS OR INDUSTRY B & O R.R.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY BALTO		13c. CITY OR TOWN TIMONIUM		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 30 CINDER ROAD			
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES H. SCHENKEL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LOUISE CLIFTON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 330-34-8234A		17. INFORMANT ADDRESS DAUGHTER					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H. A. SCLD - 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis - (c) Old Age -										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YES -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION 9 7				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6161 79 615 79					
22a. I certify that (I) (this hospital) attended the deceased from 6/15/79 to 6/15/79 , that (I) (we) last saw the deceased alive on 6/15/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Anthony F. Carozza DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 6/15/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anthony F. Carozza						22e. ADDRESS 1801 Northworth Rd Baltimore					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 6/18/1979		23c. NAME OF CEMETERY OR CREMATORY FREEDOM METH.		23d. LOCATION CITY OR TOWN COUNTY STATE CARROLL COUNTY MD.			
24. FUNERAL DIRECTOR NAME Evans Funeral						24b. ADDRESS 8802 Harford Rd		25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE Anthony M. Brady	

BP



BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13574

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
RUTH		FEMALE		WHITE	
5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE OF DEATH	
11 18 90		88 YRS.		6 15 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
GERMANY		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
ARBUTUS		4529 RIDGE DRIVE		TEACHER	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
D.C.				WASHINGTON	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	
GEORGE		ROSA		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
577-40-7586		DR. ARCHIE E. PALMER		WASHINGTON, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) 4292					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		DATE SIGNED			
EXAMINER'S NAME (TYPE OR PRINT)		DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE	
5550 BALTIMORE NATIONAL PIKE		JUN 18 1979			
BALTIMORE 28, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
CREMATION		06-16-79		SECURITY PROCESS	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		JUN 18 1979			
HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.					

41001



WILLIAMSON & CO. LTD.
1000 BATHING MACHINE RD.
BATHING MACHINE RD.
BATHING MACHINE RD.

WILLIAMSON & CO. LTD.

WILLIAMSON & CO. LTD.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EVELYN A. BULL			2a. DATE OF DEATH MONTH DAY YEAR JUNE 21, 1979		2b. HOUR 2:30A										
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 16, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.									
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1351 Sherwood Avenue						
14. FATHER'S NAME FIRST MIDDLE LAST Edwin S. Harrison, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Ketchmark			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO 705-12-5546		17. INFORMANT Edwin S. Harrison		ADDRESS 521 Pennsylvania Ave. Aurora, Illinois	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF SEVERE METABOLIC ACIDOSIS (b) Severe metabolic ACIDOSIS DUE TO, OR AS A CONSEQUENCE OF HEPATIC ENCEPALOPATHY WITH CIRRHOSIS (c) Hepatic Encephalopathy with Cirrhosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from June 20 , 19 1979 , to June 21 , 19 79 , that (I) (we) last saw the deceased alive on June 21 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Frank A. Hamilton, MD DEGREE Dr						22c. DATE SIGNED 6/21/79			22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANK A. HAMILTON, MD						
22e. ADDRESS St. Joseph Hospital						22f. ADDRESS 7600 York Rd, Towson, MD, 21204									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-23-1979			23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley			23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Maryland						
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.						25a. DATE REC'D. BY REGISTRAR JUN 22 1979			25b. REGISTRAR'S SIGNATURE Ruby McHenry						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2128

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1. STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dempsey Lance BURCH						2a. DATE OF DEATH MONTH DAY YEAR June 4, 1979		2b. HOUR 7:40P M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10/13/26		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEEL		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1114 OREMS RD	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH A. BURCH					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH SISLER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK				16b. SOCIAL SECURITY NO. 234 36 9844		17. INFORMANT MARY E. BURCH		ADDRESS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUETO, OR AS A CONSEQUENCE OF Respiratory arrest Metastatic disease Carcinoma of the bladder PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic obstructive pulmonary disease; renal insufficiency									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from May 11, 19 79, to June 4, 19 79, that (X) (we) last saw the deceased alive on June 4, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Jean Jean-Pierre						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/4/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jacques Jean-Pierre						22e. ADDRESS 9000 Franklin Square Dr. 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL			23b. DATE 6/7/79		23c. NAME OF CEMETERY OR CREMATORY CENTEARY		23d. LOCATION CITY OR TOWN COUNTY STATE BRANDENVILLE W. VA.		
24. FUNERAL DIRECTOR NAME CONNELLY F.H.						25a. DATE REC'D. BY REGISTRAR JUN 11 1979		25b. REGISTRAR'S SIGNATURE Ruthy McBrady	
ADDRESS 300 MACE AVE									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 13577	
FOR 1 - STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SARAH B. BURDETTE						2a. DATE OF DEATH MONTH DAY YEAR June 2, 1979			2b. HOUR 5 P. M.		
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR MAY 24 1903		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MULTI-MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EDITOR		12b. KIND OF BUSINESS OR INDUSTRY Newspaper			
13a. STATE MARYLAND						13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MARSHALL S. BURDETTE						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARICE JONES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 220-07-1345		17. INFORMANT ADDRESS DOROTHY SULLIVAN - 127 E. Timonium Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung with metastases of liver & stomach 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) DOE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Approx 6 mos.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1960, to June 2, 1979, that (I) (we) lost the deceased alive on May 27, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE Alfred G. Ossman Jr. M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-3-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alfred G. Ossman Jr. M.D.						22e. ADDRESS 1101 St Paul St Baltimore Md 21202					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE June 4, 79		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALTIMORE MD		23e. DATE OF BURIAL JUN 5 1979			
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD						ADDRESS 6500 YORK RD		25a. SIGNED BY REGISTRAR [Signature]			

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OFFICE OF THE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9		1 3 5 7 8	
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Clarence Coblentz Burgess				2a. DATE OF DEATH MONTH DAY YEAR June 20, 1979		2b. HOUR P 10:15 M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 2, 1903		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, Maryland MD.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Forest Haven Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Groundskeeper		12b. KIND OF BUSINESS OR INDUSTRY Cemetery	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY Baltimore 13c. CITY OR TOWN Catonsville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 41 Bloomsbury Avenue 21228	
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Burgess				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Chambers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-03-5172		17. INFORMANT ADDRESS Mrs. Ethel E. Burgess Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial congestive heart failure</u> 5070 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration pneumonia</u> DOE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Parkinson disease dementia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/19</u> , 19 <u>79</u> , to <u>6/19</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/19</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>James Evans MD</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/21/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>James Evans MD</u>		22e. ADDRESS <u>1132 N. Polley Rd, Catonsville, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/21/79		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland	
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home		301 Frederick Road ADDRESS Catonsville, Md. 21228		25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony M. Brady</u>	



13318

June 10, 1957

Dear Sir:

Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above.

Very truly yours,

John F. Kennedy

cc

John F. Kennedy Library, Boston

John F. Kennedy Library, New York

John F. Kennedy Library, Washington

John F. Kennedy Library, Chicago

John F. Kennedy Library, Los Angeles

John F. Kennedy Library, San Francisco

John F. Kennedy Library, Dallas

John F. Kennedy Library, Houston

John F. Kennedy Library, Phoenix

John F. Kennedy Library, Salt Lake City

John F. Kennedy Library, Denver

John F. Kennedy Library, Portland

John F. Kennedy Library, Seattle

John F. Kennedy Library, Minneapolis

John F. Kennedy Library, St. Paul

John F. Kennedy Library, Des Moines

John F. Kennedy Library, Omaha

John F. Kennedy Library, Lincoln

John F. Kennedy Library, Kansas City

John F. Kennedy Library, St. Louis

John F. Kennedy Library, Memphis

John F. Kennedy Library, Nashville

John F. Kennedy Library, Louisville

John F. Kennedy Library, Cincinnati

John F. Kennedy Library, Cleveland

John F. Kennedy Library, Detroit

John F. Kennedy Library, Toledo

John F. Kennedy Library, Indianapolis

John F. Kennedy Library, Columbus

John F. Kennedy Library, Dayton

John F. Kennedy Library, Cincinnati

John F. Kennedy Library, Louisville

John F. Kennedy Library, Nashville

John F. Kennedy Library, Memphis

John F. Kennedy Library, St. Louis

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John F. Kennedy Library, San Antonio

John F. Kennedy Library, Austin

John F. Kennedy Library, Fort Worth

John F. Kennedy Library, El Paso

John F. Kennedy Library, Albuquerque

John F. Kennedy Library, Santa Fe

John F. Kennedy Library, Las Vegas

John F. Kennedy Library, Reno

John F. Kennedy Library, Sacramento

John F. Kennedy Library, San Diego

John F. Kennedy Library, Long Beach

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M/7/77

1. FOR STATE REGISTRAR		7-12-79 as		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 13579	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH ESTI-MATED	
Charles		Edward		BURNETTE				6-9 1979	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Male	White	12/5/54		24 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Bluefield, W. Va.		U.S.A.		WIDOWED		DIVORCED		Baltimore County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Essex		2227 Corsica Road		Laborer- Bldg. Construction					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		---		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2805 Jefferson Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Howard		Charles Burnette		Melva		Sigman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		215-74-4350		Cynthia L. Burnette		21237. Court		21221 Maulsby	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
9109		IMMEDIATE CAUSE (a) <u>Drowning.</u>							
		DUE TO, OR AS A CONSEQUENCE OF							
		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.							
		(b)							
		DUE TO, OR AS A CONSEQUENCE OF							
		(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		11:2p.m. 19		2227 Corsica Rd. Balto. Md. 21221 Known as Norman Creek					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
		2227. Corsica Rd		2227. Corsica Rd		Balt		21221	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED					
K. S. A. H. LUNALIA		M.D. Deputy		6/11/79					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
K. S. A. H. LUNALIA		2112 Dundalk Av Balt.		21222					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
Burial		6/14/79		Roselawn Cemetery		Princeton, West Virginia			
24. FUNERAL DIRECTOR NAME		25a. DATE REGD. BY REGISTRAR		25b. REGISTRAR					
John H. Moran, Inc.		JUN 13 1979		Baltimore, Md. 21224					
3000 E. Baltimore St.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 3 5 8 0 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Elizabeth Byrne					2a. DATE OF DEATH MONTH DAY YEAR 6- 25 -79			2b. HOUR 8:00 A. M.	
3. SEX F.		4. RACE W.		5. DATE OF BIRTH MONTH DAY YEAR 8 11 1893		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Towson Convalescent Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaking	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Fork		13e. STREET ADDRESS 13525 Bottom Rd. Fork, Md. 21051			
14. FATHER'S NAME FIRST MIDDLE LAST William Burke				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-05-8343B		17. INFORMANT ADDRESS Mr. Martin E. Spangler Jr. 13525 Bottom Rd. Fork, Md. 21051					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized ASCVD 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c) 28 YRS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from DEC 19 70 , to June 15 19 79 , and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I) we did (did not) view the body after death.									
22b. SIGNATURE Robert H. Rosensteel				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/25/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Rosensteel M.D.				22e. ADDRESS 2602 Claret Dr. Fallston, Md. 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-28-79		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Md.			
24. FUNERAL DIRECTOR E.F. Passah, 11750 Belair Rd. Kingsville, Md. 21087				25a. DATE REC'D. BY REGISTRAR JUN 28 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 7 9 1 3 5 8 1							
1. DECEASED NAME (TYPE OR PRINT) ETHEL LYN CANNON		MIDDLE NIMI		LAST CANNON		2a. DATE OF DEATH MONTH DAY YEAR 6 17 79		2b. HOUR 3:45 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 24, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 87		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTO. MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 410 Colleen Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Thomas Coale				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Young					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-74-2419		17. INFORMANT ADDRESS Md. Masonic Homes, Cockeysville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) History of heart block									
19a. DATE OF OPERATION 6/17		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/17 19 79 , to 6/18 19 79 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 6/17 19 79 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.									
22b. SIGNATURE James H. Biddison, MD		DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/17/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Biddison		22e. ADDRESS 1500 E Northern Parkway, Balto.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 20, 1979		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Baltimore Co., Md.			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Rd. Balto., Md. 21212		25a. DATE REC'D. BY REGISTRAR JUN 21 1979		25b. REGISTRAR'S SIGNATURE			

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[Faint, mostly illegible text in the main body of the document, possibly a letter or report.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 13582	
1. DECEASED NAME (TYPE OR PRINT) <i>Esther Carrick</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>June 10 - 79</i>			2b. HOUR <i>1:20 A.M.</i>					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 - 10 - 01</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>U.S.A.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County MD.</i>					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Valley View Nursing Home</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE <i>MD</i>			13b. COUNTY <i>Balto</i>			13c. CITY OR TOWN <i>Balto</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>J. James</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>S. Sneed</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>1848 Yakoma Rd. 21234</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. <i>213-09-2060</i>			17. INFORMANT ADDRESS <i>Leroy W. Carrick 1848 Yakoma Rd. 21212</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary congestion</i> 1890 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>r/o Pulmonary metastases</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Cancer of (L) kidney, irradiated</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>6/4/79</i> to <i>6/10/79</i> , that (I) (we) lost <i>6/4/79</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Nguyen</i>			DEGREE			22c. DATE SIGNED <i>6/11/79</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NGUYEN</i>			22e. ADDRESS <i>6 Linlow Ct Towson 21204</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>6-12-79</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore MD</i>		
24. FUNERAL DIRECTOR NAME <i>Stansbury</i>			ADDRESS <i>6411 Windsor</i>			25a. DATE REC'D. BY REGISTRAR <i>JUN 14 1979</i>			25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>		

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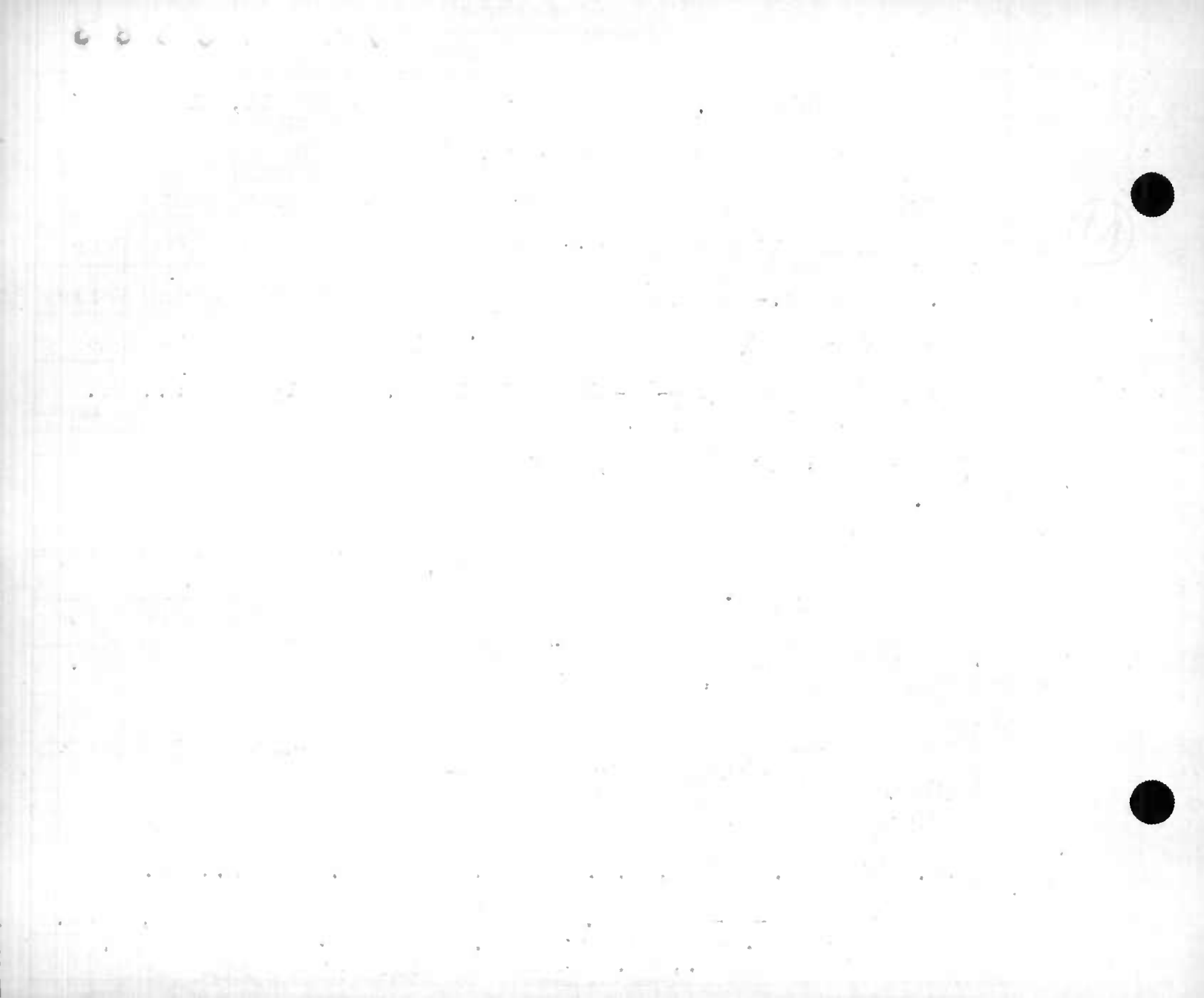


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.		1 3 5 8 3							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR MIN		
Amelie L. CARROLL						JUNE 11, 1979			10 44 AM		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
Female		White		June 30, 1888		90					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Baltimore County			MD.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Brooklandville		1021 Greenspring Valley Road						Homemaker		Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. INSIDE CITY LIMITS?			13b. STREET ADDRESS					
13a. STATE Md.			13b. CITY OR TOWN Balto.-Brooklandville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1021 Greenspring Valley Rd		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Frederick Holme Hack			Nannie Newcomer								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
No			220-44-2144			William C. Trimble			Balto., Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>4/40</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (This hospital) attended the deceased from <u>1960</u> , 19 <u>79</u> , to <u>death</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5-31</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Philip F. Wagley</u>						DEGREE <u>M.D.</u>			22c. DATE SIGNED <u>6-11-79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Philip F. Wagley, M.D.</u>						22e. ADDRESS <u>9 E. Chase St. Balto., Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		6-13-79		St. Thomas		Garrison Forest, Md.					
24. FUNERAL DIRECTOR <u>Henry W. Jenkins & Sons Co.</u> <u>4905 York Road Balto., Md. 21212</u>						25a. DATE REC'D. BY REGISTRAR <u>JUN 14 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Richard A. Brady</u>			





STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13584	
1. DECEASED NAME (TYPE OR PRINT) EMMA JANE CATES										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6-19 1979	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 13, 1933		6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-19 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD		
10. CITY OR TOWN OF DEATH Essex 21221			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 910 Martin Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver			12b. KIND OF BUSINESS OR INDUSTRY Bus 60.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 910 Martin Road 21221			
14. FATHER'S NAME FIRST MIDDLE LAST Russell Bosard						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alda Kohl					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 507 34 6662		17. INFORMANT Walter C. Cates				ADDRESS Same 21221	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Amyo trophic lateral Sclerosis 3352 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE K.S. Ahluwalia				TITLE (SPECIFY) Deputy				DATE SIGNED 6/19/79			
EXAMINER'S NAME (TYPE OR PRINT) K.S. AHLUWALIA				ADDRESS 2112 Dundalk Av. Balt 21222							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 6/21/79		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland			
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home P.A. 1407 Eastern Ave.						25a. DATE REC'D. BY REGISTRAR JUN 20 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



100-100000

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

Washington, D. C. 20535

Date: 10/10/68

Re: [illegible]

From: [illegible]

Subject: [illegible]

Reference: [illegible]

Enclosure: [illegible]

Very truly yours,

[illegible signature]

[illegible title]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Helen A. Chambers			2a. DATE OF DEATH MONTH DAY YEAR June 3, 1979			2b. HOUR 4:00P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 23, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 614 W. Chesapeake Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 614 W. Chesapeake Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Grimes					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-52-7519		17. INFORMANT ADDRESS Mrs. Jean W. Colbert Same as #13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Debility, malnutrition</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rheumatoid arthritis, arteriosclerosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Decubiti, buttocks</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours 2 weeks years.	
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> , 19 <u>69</u> , to <u>6/3</u> , 19 <u>79</u> , that (I) <u>last</u> saw the deceased alive on <u>6/2</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>viewed</u> <u>did not</u> view the body after death.									
22b. SIGNATURE DEGREE <u>Donald L. Somerville, MD</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/4/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald L. Somerville, M.D.						22e. ADDRESS 25 W. Pennsylvania Ave. Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 6, 1979		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore, Md.		
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.			ADDRESS 1050 York Road Towson, Md. 21204			25a. DATE REC'D. BY REGISTRAR JUN 6 1979		25b. REGISTRAR'S SIGNATURE <u>Rickey McLeod</u>	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 3 5 8 6

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) GENEVIEVE R CHERRY		2a DATE OF DEATH MONTH DAY YEAR 6 27 79		2b HOUR 3:00A
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 8 1 29		6 AGE (IN YEARS LAST BIRTHDAY) 49 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.
10 CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY Hecht. Co.
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTO	13c. CITY OR TOWN BALTO	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST LEON POKEYWKA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY KIEREPKA		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-26-6459	17 INFORMANT ADDRESS 2813 STANLEY POKEYWKA BRENDAN AVE		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 METASTASIS CA OF THE BREAST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5-11 19 79 , to 6-27 19 79 , that (I) (we) lost saw the deceased alive on 6-27 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.				
22b. SIGNATURE 	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-27-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. THOMAS, M.D.		22e. ADDRESS GBMC-6701 N. CHARLES ST.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 6-30-79	23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY	23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD	
24 FUNERAL DIRECTOR NAME JOHN M. WEBER & SONS INC	ADDRESS 401 S. CHESTER	25a. DATE REC'D. BY REGISTRAR JUN 29 1979	25b. REGISTRAR'S SIGNATURE 	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 9-13587	
1. DECEASED NAME (TYPE OR PRINT) Dr. John Warden Clark						2a. DATE KNOWN OF DEATH ESTI-MATED 6 3 19 79		2b. HOUR M			
3. SEX Male	4. RACE White	5. DATE OF BIRTH 11/5/34	6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD 6 3 19 79		2d. HOUR 6:20P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Woodlawn		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1701 Belmont Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician		12b. KIND OF BUSINESS OR INDUSTRY Medicine			
13a. STATE Md.			13b. COUNTY Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5719 Kenmore Road				
14. FATHER'S NAME John Howard Clark			15. MOTHER'S MAIDEN NAME Wayne Warden								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-32-2061		17. INFORMANT Mrs. Eleanor B. Clark		17. ADDRESS Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Secobarbital intoxication</u> 9501 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? 8/3/ 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject ingested overdose						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Hotel		21f. LOCATION (Ramada Inn) STREET CITY OR TOWN 1701 Belmont Ave. Woodlawn			COUNTY STATE Balto. Co. Md.			
22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Virginia L. Dolan			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 6/4/79		
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn St . Balto., Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-6-79		23c. NAME OF CEMETERY OR CREMATORY Greenmount			23d. LOCATION CITY OR TOWN Baltimore, Md.			
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212			25a. DATE REC'D. BY REGISTRAR JUN 5 1979			25b. REGISTRAR'S SIGNATURE Petrysky					

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				7 1 3 5 8 8			
1 DECEASED NAME (TYPE OR PRINT) Harrison Coates				2a DATE OF DEATH 6/19/79		2b HOUR 3:10 P.M.	
3 SEX male		4 RACE B		5. DATE OF BIRTH 12 28 30		6 AGE (IN YEARS LAST BIRTHDAY) 48	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b KIND OF BUSINESS OR INDUSTRY none	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD. 13b COUNTY BALT. 13c CITY OR TOWN Balt.				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1108 Carrollton Ave.	
14 FATHER'S NAME CLARENCE ELLSWORTH COATES				15. MOTHER'S MAIDEN NAME VIRGINIA WOODYARD			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b SOCIAL SECURITY NO. 2826544		17 INFORMANT ADDRESS MRS. IDA MAE WRIGHT 336 N. HILTON STREET	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest.. possibly 2 to stroke. 1449 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Metastatic Cancer floor of mouth. (c) Severe cachexia & anemia.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 min.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION 6/8		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY 19 HOUR A.M. MONTH DAY YEAR P.M.		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 6/8 19 79 to 6/19 19 79 , that (I) (we) last saw the deceased alive on 6/19/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE G.Y. Apostolides				DEGREE		22c DATE SIGNED 6/19/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) G.Y. APOSTOLIDES				22e ADDRESS Un. MD Hosp.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 6/23/79		23c NAME OF CEMETERY OR CREMATORY WESTVIEW MEMORIAL PARK CATONSVILLE		23d LOCATION CITY OR TOWN CATONSVILLE COUNTY BALTIMORE STATE MD.	
24 FUNERAL DIRECTOR NAME LEWIS T. GWYNN ADDRESS 4517 PARK HEIGHTS AVENUE				25a DATE REC'D. BY REGISTRAR JUN 22 1979			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Nella Elizabeth Cockerill					2a. DATE OF DEATH June 30 1979			2b. HOUR 6:00P M	
3. SEX F		4. RACE W		5. DATE OF BIRTH July 6 1903		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Balto. Highlands		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2814 Manoff Road 21227				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barmaid		12b. KIND OF BUSINESS OR INDUSTRY Tavern	
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Balto Highlands		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Granville Koon					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Isner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-12-6938		17. INFORMANT ADDRESS Lila Bealefeld/2814 Manoff Road/21227				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of the pancreas</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10) <u>ASCVD - degenerative Osteoarthritis</u> 10 years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>March 10</u> , 19 <u>62</u> , to <u>June 30</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>June 30</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>W. H. Weiss</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7-2-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. H. Weiss				22e. ADDRESS 615 Hammonds Lane - 21225					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 07/03/79		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Howard Co., Maryland			
24. FUNERAL DIRECTOR NAME Walters Funeral Home/Pratt & Stricker Streets				25a. DATE REC'D. BY REGISTRAR JUL 6 1979		25b. SIGNATURE <u>Patricia Stricker</u>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										13590 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Daniel W. Colhoun										2a. DATE KNOWN OF DEATH ESTIMATED June 15 1979 10:00 AM	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4-17-88		6. AGE (IN YEARS) LAST BIRTHDAY 91 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD June 15 1979 10:00 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC, 6701 N. Charles St. 21204				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Major		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Glyndon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Mantua Mill Road			
14. FATHER'S NAME FIRST MIDDLE LAST Peter Dudley Colhoun						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Norvel Warwick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW I				16b. SOCIAL SECURITY NO. 261-74-6421		17. INFORMANT Ella Colhoun				ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Surgery for Hemiparalysis caused by Stroke</u> DUE TO, OR AS A CONSEQUENCE OF <u>by Stroke</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST: <u>8/150</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 Days</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>ASCD Generalized</u>											
19a. DATE OF OPERATION 6/14/79				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Hemiparalysis</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR, A.M. MONTH DAY YEAR 5:30 P.M. June 13 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Driving Auto ran off Baltimore Tree</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Street</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>Mantua Mill Rd Glyndon Balto Md</u>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER DATE SIGNED 6/15/79			
EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell				ADDRESS York Road Towson, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6-19-79		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.		
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212						25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE <u>John J. Murphy</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alfred Ernest COLLEY						2a. DATE OF DEATH MONTH DAY YEAR JUNE 17, 1979		2b. HOUR: 4:00 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 31, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? England		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Multi Medical Center						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive		12b. KIND OF BUSINESS OR INDUSTRY Hotel	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1302 Crownfield Court			
14. FATHER'S NAME FIRST MIDDLE LAST Alfred Colley						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zoe ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Mrs. Valerie Obenstine Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 515- DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Pulmonary Interstitial Fibrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cor Pulmonale											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from JAN 23, 1979 to JUNE 17, 1979 , that (I) (we) last saw the deceased alive on JUNE 15, 1979 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Walter A. Welzant, MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/18/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Walter Welzant, M.D.						22e. ADDRESS St. Joseph's Hospital Towson, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-19-79		23c. NAME OF CEMETERY OR CREMATORY Moreland		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md.					
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co.						25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE Robert K. Bandy			
24b. ADDRESS 4905 York Road Balto., Md. 21212											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 3 5 9 2

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Frances E. Conkey			2a. DATE OF DEATH MONTH DAY YEAR 6 16 79			2b. HOUR/PM 3:30 AM			
3. SEX Female		4. RACE Cauca.		5. DATE OF BIRTH MONTH DAY YEAR 5 16 1913		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS IF UNDER 1 YEAR MONTHS DAYS HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) xxxxxxxxteacher		12b. KIND OF BUSINESS OR INDUSTRY Avoca Sch.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE Md.		13b. COUNTY Balti.		13c. CITY OR TOWN Woodlawn		13e. STREET ADDRESS 20 Gwynn Lake Drive			
14. FATHER'S NAME FIRST MIDDLE LAST John Reap					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mariah Grimes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 203-05-2123		17. INFORMANT ADDRESS Avoca, Pa. 18641 O'Malley Funeral Home, 728 Main St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS; ANEMIA									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-15 , 19 79 , to 6-16 , 19 79 , that (I) (we) lost saw the deceased alive on 6-16 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature] DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-16-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO B. CONANAN MD.						22e. ADDRESS BCEH - RANDALLSTOWN MD. 21133			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE June 19, 1979		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION CITY OR TOWN COUNTY STATE Avoca, Luzerne, Pa.		
ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214						25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

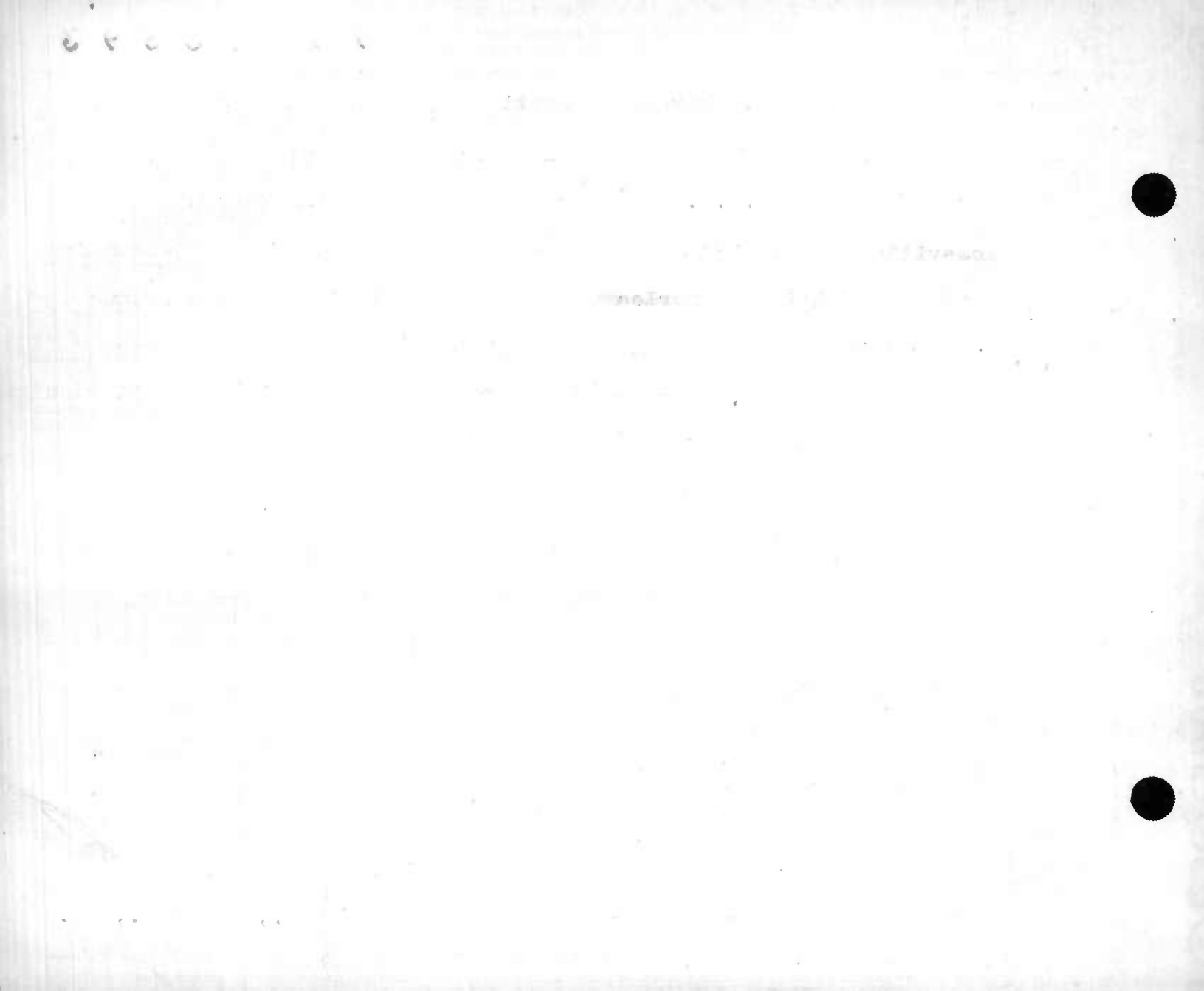
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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 3 5 9 3			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Emily Theresa Conti								June 29, 1979				7:20P M	
3 SEX		4 RACE		5. DATE OF BIRTH				6 AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR	
FEMALE		WHITE		1 - 20 - 1907				71 YRS				MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.						Baltimore County				MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Rossville		Franklin Square Hospital				Housewife				Homemaking			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13. STREET ADDRESS			
Maryland				Baltimore		Overlea		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4213 Fullerton Avenue			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST Frederick Mehl				FIRST MIDDLE LAST Amilia Hammer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
NO				215-40-1448		Ambrose Joseph Conti 4213 Fullerton Av							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF Ventricular arrythmia (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from June 29 19 79 to June 29 19 79, that (we) last saw the deceased alive on June 29 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE				22c. DATE SIGNED							
Michael Koger MD						6/29/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Michael Koger MD		9000 Franklin Square Drive, 21237											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		7-3-79		Gardens of Faith				Balto., Balto., Md.					
24 FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
LASSAHN FUNERAL HOME 7401 Belair Road						JUL 3 1979		Anthony McCready					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 3 5 9 4 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Anna M. Courtney					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR June 30th 1979 10:25 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 13, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.					13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Schad					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Holdefer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-46-2293		17. INFORMANT ADDRESS Mr. Charles F. Courtney - 3727 Bayonne Ave. 21206						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of liver 1533 DUE TO, OR AS A CONSEQUENCE OF (b) Primary Carcinoma of sigmoid Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Cardio Vascular Disease -										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 6-23 19 79, to 6-30 19 79, that (I) (we) lost saw the deceased alive on 6-30 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Mary Mani Pulimood MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/30/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary Mani Pulimood, M.D.					22e. ADDRESS 7620 York Road, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-3-79		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.				
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206 ADDRESS					25a. DATED BY REG. NO. 25b. REG. EXPIRATION DATE JUL 5 1979					

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TO HOSPITAL SURVIVING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR				REG. NO. 7 9 1 3 5 9 5					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
FIRST MIDDLE LAST Alverta L. CRESWELL				MONTH DAY YEAR June 12 1979				5:33a M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		White		Jan. 31, 1921		58			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Baltimore		U.S.A.				Baltimore County MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK, OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore County		Franklin Square Hospital				Textile Mill		Retired	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Baltimore				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		931 Wampler Road	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Basil Creswell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS			
No				214-20-8202		Mrs James Weiman 22 Spicewood Court			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>June 12</u> , 19 <u>79</u> , to <u>June 12</u> , 19 <u>79</u> , that (we) lost saw the deceased alive on <u>June 12</u> , 19 <u>79</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (view the body after death).									
22b. SIGNATURE <u>Kai-Fu Chow</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>6/12/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Fu Chow				22e. ADDRESS 9000 Franklin Square Drive 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		6-15-1979		Moreland Memorial		Baltimore County, Maryland			
24 FUNERAL DIRECTOR NAME Lilly & Zeiler Inc. 1901-07 Eastern Avenue						25. DATE REC'D BY REGISTRAR JUN 14 1979		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

68001 21



TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 3 5 9 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAZIE MARIAN CROCKEN			2a. DATE OF DEATH MONTH DAY YEAR June 11, 1979			2b. HOUR 9:40 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 14, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Armocost Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Own home		13a. STREET ADDRESS 3107 Rosalie Ave. 21234		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Oliver W. Holmes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara (UNKNOWN)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-18-1859	
17. INFORMANT ADDRESS Balto., Md. 21234		18. NAME OF INFORMANT Joseph F. Crocken - 3107 Rosalie Ave.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4049 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal Vascular Disease</u> (c) <u>5+ yrs</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>79</u> , to <u>11 June</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>9 June</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Charles F. O'Donnell</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED June 12, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. O'Donnell, M.D.		22e. ADDRESS 7501 York Rd.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 13/79		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. Baltimore, Maryland 21214				25a. DATE REC'D. BY REGISTRAR JUN 13 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

0 9 0 2 1 0 0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached for use as the burial-transit permit. Then please remove card on page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					7 9 1 3 5 9 7 REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) ROBERT LEE CROWTHER					2a. DATE OF DEATH MONTH DAY YEAR JUNE 26, 1979			2b. HOUR 7:57 P M		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 22, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care-Towson 509 E. Joppa Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Auto Assembly		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1001 Reverdy Rd. Plant	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Lee Crowther, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Hume					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-01-7418		17. INFORMANT ADDRESS Mrs. Kathryn Wood Crowther Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Taromonalans</u> 185- DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Acid prostatic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF: (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Septic pneumonia.</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/3/78</u> , 19 <u>78</u> , to <u>6/26</u> , 19 <u>79</u> , that (I) <u>was</u> last saw the deceased alive on <u>6/19</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> and did not view the body after death.										
22b. SIGNATURE <u>Conrad L Richter</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/22/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Conrad Richter, M.D.					22e. ADDRESS 3128 Harford Rd. Baltimore, Md. 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 30, 1979		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore Co., Md.			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.					ADDRESS 6500 York Rd. Balto., Md.		25a. DATE REC'D. BY REGISTRAR JUL 5 1979			

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11. *Journal of the American Medical Association*, 277, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674,

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 1 3 5 9 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Daniel Cupp			2a. DATE OF DEATH MONTH DAY YEAR June 10 1979		2b. HOUR 11:30 P M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 23 1912		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rogers Forge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 215 A Rogers Forge Rd. 21212				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Retail Sales	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Rogers Forge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Harry William Cupp			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hinch						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 215-03-4413		17. INFORMANT ADDRESS Barbara Beam 4004 Kahlstone Rd 21236					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Laurence C. Post				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-11-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Laurence C. Post				22e. ADDRESS 6805 York Rd. 21212					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6-11-79		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home				ADDRESS 6500 York Rd. 21212		25a. DATE REC'D. BY REGISTRAR JUN 15 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Name	Address	City	State
John D. Smith	123 Main St.	New York	NY
Mary E. Jones	456 Elm St.	New York	NY
Robert L. Brown	789 Oak St.	New York	NY
Elizabeth C. White	101 Pine St.	New York	NY
James H. Black	234 Cedar St.	New York	NY
William F. Green	567 Birch St.	New York	NY
Margaret A. Hall	890 Spruce St.	New York	NY
Charles K. Young	1122 Ash St.	New York	NY
Dorothy M. King	1445 Willow St.	New York	NY
Frank J. Scott	1768 Maple St.	New York	NY
Helen S. Adams	2091 Elm St.	New York	NY
George W. Baker	2414 Oak St.	New York	NY
Betty L. Nelson	2737 Pine St.	New York	NY
Edward R. Hill	3060 Cedar St.	New York	NY
Lillian D. Wright	3383 Birch St.	New York	NY



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 3 5 9 9 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) DOROTHY MORGAN DAVIS					2a. DATE OF DEATH MONTH DAY YEAR 6 04 79 2b. HOUR 12:50A					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 10, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY State of Md		
13a. STATE Maryland			13b. COUNTY City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1001 St. Paul St.	
14. FATHER'S NAME FIRST MIDDLE LAST George F. Morgan					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy M. Carter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.			16b. SOCIAL SECURITY NO. 220-10-4775		17. INFORMANT ADDRESS 6112 Parkway Dr. James D. Morgan Sr. Laurel, Md. 20811					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 1489 DUE TO, OR AS A CONSEQUENCE OF (b) TERMINAL CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) CANCER OF HYPOPHARYNX									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-15</u> , 19 <u>79</u> , to <u>6-04</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-04</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>[Signature]</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6-04-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIS POLLACHI					22e. ADDRESS GBMC-6701 N. CHARLES ST.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 6/5/79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Alex. Va			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20810					25a. DATE REC'D. BY REGISTRAR JUN 5 1979			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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DAVIS

DOROTHY

BALTIMORE COUNTY

68MC-6701 W. CHARLES ST.

TOWSON

RESPIRATORY ARREST

TERMINAL CANCER

CANCER OF HYPOPHARYNX

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6-29

6-04-70

68MC-6701 W. CHARLES ST.

68MC-6701 W. CHARLES ST.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>EDWIN L. DAVIS</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6 12 79.</i>			2b. HOUR M <i></i>	
3. SEX <i>M.</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3-25-23</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>56</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Oldtown, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Rossville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Franklin Square Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Professional</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>				13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William W. Davis</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jeanette Hamilton</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <i>217-14-4883</i>		17. INFORMANT ADDRESS <i>Mrs. Mary Maxine Davis - 6312 Kenwood Ave.</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (d) <i>410- PROBABLE ACUTE MYOCARDIAL INFARCTION</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ARTERIO SCLEROTIC HEART DISEASE</i>			
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>L.F. Auer</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>L.F. Auer</i>				22e. ADDRESS <i>7401 OSLER DR. 21204</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6-15-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto, Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>John C. Miller Inc-6415 Belair Rd.-21206</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 18 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 3 6 0 1	
1- FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) Pauline E. DEANGELIS			2a. DATE OF DEATH MONTH DAY YEAR June 29, 1979		2b. HOUR 5:15P M
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 15, 1918	6. AGE (IN YEARS LAST BIRTHDAY) 61		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10 CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Clerk	12b. KIND OF BUSINESS OR INDUSTRY Foodarama	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Rosedale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 30 King Charles Circle
14 FATHER'S NAME FIRST MIDDLE LAST Anthony DeFazio		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernadine Lord			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 216-07-2074	17 INFORMANT ADDRESS Mr. Thomas D. DeAngelis 30 King Charles Cir			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest 1519 DUE TO, OR AS A CONSEQUENCE OF (b) Upper gastrointestinal bleeding Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Stomach carcinoma					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) this hospital attended the deceased from June 25 19 79 to June 29 19 79, that (X) (we) lost saw the deceased alive on June 29 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>Musa A. Hind</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Musa A. Hind		22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-2-1979	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.		ADDRESS 5305 Harford Rd. Balto; Md.		25a. DATE REC'D. BY REGISTRAR JUL 2 1979	25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				9 1 3 6 0 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JOSEPH DeNittis				2a. DATE OF DEATH MONTH DAY YEAR 2 1979			
3. SEX M.				2b. HOUR 5:00PM			
4. RACE W.		5. DATE OF BIRTH MONTH DAY YEAR 5/14/1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 Yrs.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CO. MD.		MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF BOTH SUCH PRESENT, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (IF WORKING, GIVE NATURE OF WORKING LIFE) RES. OWNER.		12b. KIND OF BUSINESS OR INDUSTRY RES.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Md.		13b. CITY BALTO.		13c. CHARTERED TOWN BALTO. TOWN		13e. STREET ADDRESS 906 TRINITY ST.	
14. FATHER'S NAME BIAGGIO De Nittis				15. MOTHER'S MAIDEN NAME DONATA VECERA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-26-6385A		17. INFORMANT ADDRESS MRS. MARY DeNittis 906 TRINITY ST.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Renal Failure							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1539 } DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of colon w/ Liver metastasis							
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Mar 16 19 79 , to JUNE 2 19 79 , that (I) (we) last saw the deceased alive on June 2 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Erlando Romero				DEGREE		22c. DATE SIGNED 6/2/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERLANDO ROMERO M.D.				22e. ADDRESS 7620 York Rd. Towson Md 21204 ST. JOSEPH Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT		23b. DATE 6/5/79		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH. KENWOOD AVE. BALTO.		23d. LOCATION CITY OR TOWN COUNTY STATE MD.	
24. FUNERAL DIRECTOR NAME DELLA NOCE & SONS. 322 S. HIGH ST. BALTO. Md.				25a. DATE REC'D. BY REGISTRAR JUN 4 1979		25b. REGISTRAR'S SIGNATURE Patricia McHenry	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                     |  |  |                                   |  |  |
|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                     |                                                                                                           |                                                                                                                                                             | 2a. DATE OF DEATH                                                   |  |  | 2b. HOUR                          |  |  |
| FIRST MIDDLE LAST<br>Roy Dennis                                                         |                                                                                                           |                                                                                                                                                             | MONTH DAY YEAR<br>June 26 79                                        |  |  | 3:35P M                           |  |  |
| 3. SEX                                                                                  | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  | 7. IF UNDER 1 YEAR                |  |  |
| M                                                                                       | W                                                                                                         | MONTH DAY YEAR<br>9/13/98                                                                                                                                   | 80                                                                  |  |  | MONTHS DAYS HOURS MIN.            |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                               | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     |  |  |                                   |  |  |
| MD.                                                                                     | USA                                                                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                        |                                                                     |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| ROSSVILLE                                                                               | FRANKLIN SQ.                                                                                              |                                                                                                                                                             | Baltimore County MD.                                                |  |  | TAVERN                            |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                                                                                                           |                                                                                                                                                             |                                                                     |  |  |                                   |  |  |
| 13a. STATE                                                                              | 13b. COUNTY                                                                                               | 13c. CITY OR TOWN                                                                                                                                           | 13d. INSIDE CITY LIMITS?                                            |  |  | 13e. STREET ADDRESS               |  |  |
| MD.                                                                                     | BALTO                                                                                                     | FRANKLIN                                                                                                                                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 823 WOODROW AVE                   |  |  |
| 14. FATHER'S NAME                                                                       |                                                                                                           |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME                                            |  |  |                                   |  |  |
| FIRST MIDDLE LAST<br>FRANK A. DENNIS                                                    |                                                                                                           |                                                                                                                                                             | FIRST MIDDLE LAST<br>MARGARET ANDERSON                              |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                    |                                                                                                           |                                                                                                                                                             | 16b. SOCIAL SECURITY NO                                             |  |  | 17. INFORMANT ADDRESS             |  |  |
| NO                                                                                      |                                                                                                           |                                                                                                                                                             | 216-03-6467                                                         |  |  | HARRY W. DENNIS 823 WOODROW       |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Respiratory Arrest

496-  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) Bilateral Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c) Cachexia Chronic Obstructive Pulmonary Disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

|                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                        |  |                                                                                |  |                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?                                                                  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>June 22</u> , 19 <u>79</u> , to <u>June 26</u> , 19 <u>79</u> , that (X) (we) last<br>saw the deceased alive on <u>June 26</u> , 19 <u>79</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (X) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                |  |                                                                   |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                   |  | DEGREE                                                                 |  | 22c. DATE SIGNED                                                               |  |                                                                   |  |
| A. Raza Raza                                                                                                                                                                                                                                                                                                                                                                     |  | MD                                                                     |  | 6/26/79                                                                        |  |                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                            |  | 22e. ADDRESS                                                           |  |                                                                                |  |                                                                   |  |
| A. Raza M.D.                                                                                                                                                                                                                                                                                                                                                                     |  | 9000 Franklin Square Drive                                             |  |                                                                                |  |                                                                   |  |

|                                              |  |           |  |                                                          |  |                                            |  |
|----------------------------------------------|--|-----------|--|----------------------------------------------------------|--|--------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) |  | 23b. DATE |  | 23c. NAME OF CEMETERY OR CREMATORY                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| BURIAL                                       |  | 6/29/79   |  | OAK LAWN                                                 |  | BALTO. MD.                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS         |  |           |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |  |                                            |  |
| J.E. CONNELLY 300 MACE                       |  |           |  | JUL 2 1979 History McCreedy                              |  |                                            |  |

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00001





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 13604

FOR  
1. STATE  
REGISTRAR

|                                                            |  |                                               |                                                    |                                                                                                                                                             |  |                                                                  |  |
|------------------------------------------------------------|--|-----------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Marie C. Depkin</b> |  |                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>6-26-79</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>10<sup>30</sup></b> M                             |  |
| 3. SEX<br><b>Female</b>                                    |  | 4. RACE<br><b>White</b>                       |                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>8-22-1894</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD. |  |

|                                                                                                                       |  |                                                                                                                                         |  |                                                                                      |  |                                                                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care - Towson</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> |  | 13b. COUNTY<br><b>-</b>                                                                                                                 |  | 13c. CITY OR TOWN<br><b>BALTO.</b>                                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES J. SCHERER</b>                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA BOLST.</b>                                                                     |  |                                                                                      |  |                                                                                                 |  |

|                                                                                   |  |                                                |  |                                                                               |  |  |  |
|-----------------------------------------------------------------------------------|--|------------------------------------------------|--|-------------------------------------------------------------------------------|--|--|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>216-46-1577</b> |  | 17. INFORMANT<br>ADDRESS<br><b>Dr. Charles E. Depkin - 1718 Anglenide Rd.</b> |  |  |  |
|-----------------------------------------------------------------------------------|--|------------------------------------------------|--|-------------------------------------------------------------------------------|--|--|--|

|                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br><b>4409</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerosis sclerotic vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|                                                                                                                                                          |  |                                                                        |  |                                                                                |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                            |  |

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|                                                                |  |                                                         |  |                                    |  |
|----------------------------------------------------------------|--|---------------------------------------------------------|--|------------------------------------|--|
| 22b. SIGNATURE<br><b>Walter T. Kees</b>                        |  | DEGREE                                                  |  | 22c. DATE SIGNED<br><b>6/26/79</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER T. KEES</b> |  | 22e. ADDRESS<br><b>MANOR CARE NURSING HOME - Towson</b> |  |                                    |  |

|                                                            |  |                             |  |                                                                |  |                                                                  |  |
|------------------------------------------------------------|--|-----------------------------|--|----------------------------------------------------------------|--|------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>6/29/79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEMETERY</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO., MD.</b> |  |
|------------------------------------------------------------|--|-----------------------------|--|----------------------------------------------------------------|--|------------------------------------------------------------------|--|

|                                                                              |  |                                                     |  |                                                  |  |
|------------------------------------------------------------------------------|--|-----------------------------------------------------|--|--------------------------------------------------|--|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Nancy Miller 7527 Harford Rd.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 28 1979</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |
|------------------------------------------------------------------------------|--|-----------------------------------------------------|--|--------------------------------------------------|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |  |                                                                                      |  | 7 9 1 3 6 0 5<br>REG. NO.                                                                                                  |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph Conrad Dernetz                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 17, 1979                                                                                                        |  |                                                                                      |  | 2b. HOUR<br>9:45 AM                                                                                                        |  |                                              |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>White                                                                                                                      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 27, 1918                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS                                            |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |                                                                                                                            |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Deputy Director  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>of Immigration                                                                        |  |                                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |  | 13b. COUNTY<br>Baltimore                                                                                                                                    |  | 13c. CITY OR TOWN<br>Towson                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>1109 Hampton Garth    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph A. Dernetz                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary C. Buettner                                                                                           |  |                                                                                      |  |                                                                                                                            |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II                                                                      |  | 17. INFORMANT<br>213-01-2967                                                                                                                                |  | Mildred L. Dernetz Same as #13.                                                      |  |                                                                                                                            |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cirrhosis of the Liver</u><br>5715<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                      |  |                                                                                                                            |  |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                      |  |                                                                                                                            |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 5</u> , 19 <u>79</u> , to <u>June 17</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 17</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                          |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |                                              |  |
| 22b. SIGNATURE<br><u>Rose Gomez</u> M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |  | DEGREE                                                                                                                                                      |  |                                                                                      |  | 22c. DATE SIGNED<br><u>June 17/79</u>                                                                                      |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Rose Gomez, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       |  | 22e. ADDRESS<br>9000 Franklin Square Drive 21237                                                                                                            |  |                                                                                      |  |                                                                                                                            |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br>June 18, 1979                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Crematory                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                    |  |                                                                                                                            |  |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |  | ADDRESS<br>1050 York Road                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 19 1979                                         |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McCready</u>                                                                      |  |                                              |  |

60001 VV

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13606

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  |                                                |                                                                                                                                                             |  |                                                                               |  |                                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SAMUEL DIAMOND</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                  | 2a. DATE OF DEATH MONTH DAY YEAR <b>6 4 79</b> |                                                                                                                                                             |  | 2b. HOUR <b>1148</b> M                                                        |  |                                                                                                                               |  |
| 3. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE <b>CAUC</b>                                                                                                              |                                                | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 25 21</b>                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                          |                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO COUNTY</b> MD.                  |  |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3927 CHAFFEY RD</b> |                                                |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALES</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>APPLIANCE</b>                                                                            |  |
| 13a. STATE <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY <b>BALTO</b>                                                                                                         |                                                | 13c. CITY OR TOWN <b>RANDALLSTOWN</b>                                                                                                                       |  | 13e. STREET ADDRESS <b>3927 CHAFFEY RD.</b>                                   |  | # <b>21133</b>                                                                                                                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>BENJAMIN DIAMOND</b>                                                                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ESTHER MERTENBAUM</b>                                                              |                                                |                                                                                                                                                             |  |                                                                               |  |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO. <b>ARMY-WWII</b>                                                                                        |                                                | 17. INFORMANT <b>MRS. CAROL GOODMAN</b><br><b>3927 CHAFFEY RD., RANDALLSTOWN, MD 21133</b>                                                                  |  |                                                                               |  |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>ACUTE RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC ADENOCARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                                                          |  |                                                                                                                                  |                                                |                                                                                                                                                             |  |                                                                               |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                              |  |                                                                                                                                  |                                                |                                                                                                                                                             |  |                                                                               |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |                                                |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                               |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                               |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital attended the deceased from <b>6/4</b> <b>19</b> <b>79</b> to <b>6/4</b> <b>19</b> <b>79</b> , that (I) last saw the deceased alive on <b>6/4</b> <b>19</b> <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) not view the body after death. |  |                                                                                                                                  |                                                |                                                                                                                                                             |  |                                                                               |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Sol Levinson</b>                                                                                                                                                                                                                                                                                                                            |  | DEGREE                                                                                                                           |                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |                                                                               |  | 22c. DATE SIGNED<br><b>6/5/79</b>                                                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SOL LEVINSON</b>                                                                                                                                                                                                                                                                                                        |  | ADDRESS <b>2435 W. BALDWIN RD BALTO MD 21215</b>                                                                                 |                                                |                                                                                                                                                             |  |                                                                               |  |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                          |  | 23b. DATE <b>JUNE 5, 1979</b>                                                                                                    |                                                | 23c. NAME OF CEMETERY OR CREMATORY <b>BETH JACOB</b>                                                                                                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>FINKSBURG CARROLL MD</b>        |  |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>                                                                                                                                                                                                                                     |  |                                                                                                                                  |                                                | 25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. McElroy</b>                            |  |                                                                                                                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

13607

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              |                                                                                                        |                                                                                                                                                             |                                                                                                                                        |                                                                                                          |                                                                      |                                     |                                   |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------|-----------------------------------|----------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Andrew Joseph DIMAIO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              | 2a. DATE OF DEATH<br>Month <b>6</b> Day <b>6</b> Year <b>79</b>                                        |                                                                                                                                                             |                                                                                                                                        | 2b. HOUR p<br><b>3:01</b> M                                                                              |                                                                      |                                     |                                   |                                              |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>Caucasian</b>                                                  |                                                                                                        | 5. DATE OF BIRTH<br><b>1-13-79</b>                                                                                                                          |                                                                                                                                        | 6. AGE (In years last birthday)<br>YRS. <b>4</b> MONTHS <b>24</b> DAYS                                   |                                                                      | IF UNDER 1 YEAR<br>IF UNDER 24 HRS. |                                   |                                              |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |                                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                        | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.                                                        |                                                                      |                                     |                                   |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Franklin Square</b> |                                                                                                                                                             |                                                                                                                                        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Infant</b> |                                                                      |                                     | 12b. KIND OF BUSINESS OR INDUSTRY |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              | 13b. COUNTY<br><b>Balto.</b>                                                                           |                                                                                                                                                             | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                   |                                                                                                          | 13e. STREET AND NUMBER<br><b>21237 2347 Hamiltowne Circle</b>        |                                     |                                   |                                              |  |
| 14. FATHER'S NAME First <b>Weido</b> Middle <b>DiMaio</b> Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              | 15. MOTHER'S MAIDEN NAME First <b>Emma</b> Middle <b>Simmons</b> Last                                  |                                                                                                                                                             |                                                                                                                                        |                                                                                                          |                                                                      |                                     |                                   |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              | 16b. SOCIAL SECURITY NO.<br><b>-</b>                                                                   |                                                                                                                                                             | 17. INFORMANT Address<br><b>Mr. &amp; Mrs. Weido DiMaio, 2347 Circle</b>                                                               |                                                                                                          |                                                                      |                                     |                                   |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b><br><b>5609</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Intersusception</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) |  |                                                                              |                                                                                                        |                                                                                                                                                             |                                                                                                                                        |                                                                                                          |                                                                      |                                     |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                        |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                   |                                                                                                          | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                     |                                   |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/><br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |                                                                                                        |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                        |                                                                                                          |                                                                      |                                     |                                   |                                              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                        |                                                                                                                                                             | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                           |                                                                                                          |                                                                      |                                     |                                   |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/6/</b> , 19 <b>79</b> to <b>6/6</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/6/</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                    |  |                                                                              |                                                                                                        |                                                                                                                                                             |                                                                                                                                        |                                                                                                          |                                                                      |                                     |                                   |                                              |  |
| 22b. SIGNATURE<br><b>Eisei Henzan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                                                        |                                                                                                                                                             | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                                                                                          |                                                                      | 22c. DATE SIGNED<br><b>6/6/79</b>   |                                   |                                              |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Eisei Henzan, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                              |                                                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>9000 Franklin Square Drive</b>                                                                                      |                                                                                                          |                                                                      |                                     |                                   |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>6/8/79</b>                                                   |                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>                                                                                             |                                                                                                                                        | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                              |                                                                      |                                     |                                   |                                              |  |
| 24. FUNERAL DIRECTOR<br><b>Zannino Funeral Home, 263 S. Conkling</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                                                        |                                                                                                                                                             | 25. REC'D BY REGISTRAR<br><b>JUN 8 1979</b>                                                                                            |                                                                                                          | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                     |                                     |                                   |                                              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |                                                |                                                                                                                                                         |  |                                                                                              |                                  |                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      | REG. NO. 13608                                 |                                                                                                                                                         |  |                                                                                              |                                  |                                                                                                                         |  |
| 1 DECEASED NAME (TYPE OR PRINT) <b>BERTHA E DOEGAN</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      | 2a. DATE OF DEATH MONTH DAY YEAR <b>6-1-79</b> |                                                                                                                                                         |  |                                                                                              | 2b. HOUR <b>9<sup>55</sup></b> M |                                                                                                                         |  |
| 3 SEX <b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                  |  | 4 RACE <b>WHITE</b>                                                                                                                  |                                                | 5. DATE OF BIRTH MONTH DAY YEAR <b>01-16-99</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS                                                |                                  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN                                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>                                                                                            |                                                | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. Co.</b> MD                                     |                                  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH <b>ESSEX</b>                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RIVERVIEW NURS. CENTRE</b> |                                                |                                                                                                                                                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSE</b>                   |                                  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a. STATE <b>MD.</b>                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY <b>BALTO</b>                                                                                                             |                                                | 13c. CITY OR TOWN <b>ESSEX</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN ALFORD</b>                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SEBRE</b>                                                                              |                                                | 13e. STREET ADDRESS <b>1226 340 E. RIVERSIDE AVE.</b>                                                                                                   |  |                                                                                              |                                  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO. <b>213-16-3228</b>                                                                                          |                                                | 17. INFORMANT <b>MARY RISTON</b>                                                                                                                        |  |                                                                                              | ADDRESS <b>ABOVE</b>             |                                                                                                                         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                                                                      |                                                |                                                                                                                                                         |  |                                                                                              |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>10 yrs.</b>                                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                   |  |                                                                                                                                      |                                                |                                                                                                                                                         |  |                                                                                              |                                  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |                                                |                                                                                                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                 |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                          |  |                                                                                              |                                  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |                                                | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                              |                                  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                          |  |                                                                                                                                      |                                                |                                                                                                                                                         |  |                                                                                              |                                  |                                                                                                                         |  |
| 22b. SIGNATURE <b>M. Rainess</b> DEGREE <b>M.D.</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      |                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  |                                                                                              |                                  | 22c. DATE SIGNED <b>6-2-79</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MORRIS RAINESS, M.D.</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |                                                | 22e. ADDRESS <b>1105 OLD EASTERN AVE, Balto md 21221</b>                                                                                                |  |                                                                                              |                                  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                              |  | 23b. DATE <b>6/5/79</b>                                                                                                              |                                                | 23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE</b>                                                                                                   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>                                     |                                  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>J.G. CONNELLY 300 MACE</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |                                                | 25a. DATE REC'D. BY REGISTRAR <b>JUN 7 1979</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE <b>Anthony McElroy</b>                                            |                                  |                                                                                                                         |  |

MEDICAL CERTIFICATION



60001



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                           |                                                                                                                            |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)<br>MARIE A. DONNELLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>JUNE 25, 1979                                                                                                    |                                                                                                 |                                                           | 2b. HOUR<br>2:10 a.m.                                                                                                      |                                              |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4 RACE<br>Caucasian                                                                                                             |                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 4, 1915                                                                                                             |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.                                                      |                                                           | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          |                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |                                                           |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SAINT JOSEPH HOSPITAL |                                                                     |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                      |                                                           | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                                                                                  |                                              |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY<br>-                                                                                                                |                                                                     | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           | 13e. STREET ADDRESS<br>34 N. Curley Street 21224                                                                           |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Robert V. Clifford                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Marie Hook                                                                                             |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br>215-64-8480                             |                                                                                                                                                             | 17. INFORMANT ADDRESS<br>8519 Bella Vista Dr.<br>Ronald Donnelly (son) 21206                                                                         |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of endometrium and</u><br>1820<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Intestinal obstruction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                  |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                           |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                             |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                 | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                       |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 29</u> , 19 <u>79</u> , to <u>June 25</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 25</u> , 19 <u>79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><i>A. A. Alecce</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 |                                                           | 22c. DATE SIGNED<br>6/25/79                                                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Andrew A. Alecce, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | 22e. ADDRESS<br>7401 Osler Drive, Towson, MD 21204                                                                                                   |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                 | 23b. DATE<br>6/29/79                                                |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.                                                                                             |                                                                                                 | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |                                                                                                                            |                                              |
| 24. FUNERAL DIRECTOR<br>Schamunek Funeral Home, Inc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                 | 3331 Brehms Lane<br>Balto. Md. 21213                                |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 26 1979                                                                                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>Jeffrey H. Brady</i>     |                                                                                                                            |                                              |

4 0 0 2 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 3 6 1 0

|                                                                                                                                                          |  |                                                                                                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                   |  | 2a. DATE OF DEATH                                                                                                                                                                                                |  | MONTH DAY YEAR                                                                                                                                           |  | 2b. HOUR                                                                                                                                                                                                                                                                                                      |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                         |  | FIRST MIDDLE LAST                                                                                                                                                                                                |  | 6 28 79                                                                                                                                                  |  | 1 45 P.M.                                                                                                                                                                                                                                                                                                     |  |
| 3 SEX                                                                                                                                                    |  | 4 RACE                                                                                                                                                                                                           |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                                                                                                                                                                                               |  |
| Female                                                                                                                                                   |  | White                                                                                                                                                                                                            |  | May 6, 1889                                                                                                                                              |  | 90 YRS.                                                                                                                                                                                                                                                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                                                                                                                                                                          |  |
| Maryland                                                                                                                                                 |  | U.S.A.                                                                                                                                                                                                           |  |                                                                                                                                                          |  | Baltimore County MD.                                                                                                                                                                                                                                                                                          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                                                                           |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                             |  |
| Randallstown                                                                                                                                             |  | Baltimore County General Hospital                                                                                                                                                                                |  | Seamstress                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                               |  |
| 13a. STATE                                                                                                                                               |  | 13b. CITY OR TOWN                                                                                                                                                                                                |  | 13c. STREET ADDRESS                                                                                                                                      |  | 13d. INSIDE CITY LIMITS?                                                                                                                                                                                                                                                                                      |  |
| Maryland                                                                                                                                                 |  | Baltimore                                                                                                                                                                                                        |  | Randallstown                                                                                                                                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                           |  |
| 14. FATHER'S NAME                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                                         |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                      |  |
| George W. Brookhart                                                                                                                                      |  | Mary L. Hyland                                                                                                                                                                                                   |  | No                                                                                                                                                       |  | 216-01-6962                                                                                                                                                                                                                                                                                                   |  |
| 17. INFORMANT                                                                                                                                            |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD. DUE TO, OR AS A CONSEQUENCE OF (c) 4292 |  | 19. DATE OF OPERATION                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                              |  |
| Mrs. Mary T. Garner                                                                                                                                      |  | 3836 Terka Circle Randallstown, Md. 21133                                                                                                                                                                        |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                      |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  | 22a. CERTIFY that (I) (this hospital) attended the deceased from 7:11, 1979, to 8:12, 1979, that (I) (we) lost saw the deceased alive on 6/28, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |
| 22b. SIGNATURE                                                                                                                                           |  | 22c. DATE SIGNED                                                                                                                                                                                                 |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                    |  | 22e. ADDRESS                                                                                                                                                                                                                                                                                                  |  |
| Robert Kroopnick                                                                                                                                         |  | 6/28/79                                                                                                                                                                                                          |  | Robert Kroopnick                                                                                                                                         |  | 8726 Liberty Road                                                                                                                                                                                                                                                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                |  | 23b. DATE                                                                                                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                       |  |
| Burial                                                                                                                                                   |  | 6/30/79                                                                                                                                                                                                          |  | Druid Ridge Cemetery                                                                                                                                     |  | Pikesville, Balto. Md.                                                                                                                                                                                                                                                                                        |  |
| 24. FUNERAL DIRECTOR                                                                                                                                     |  | 25. DATE REC'D. BY REGISTRAR                                                                                                                                                                                     |  | 25a. REGISTRAR'S SIGNATURE                                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                    |  |
| Loring Byers Funeral Directors, P.A.                                                                                                                     |  | JUL 3 1979                                                                                                                                                                                                       |  | Loring Byers                                                                                                                                             |  | Loring Byers                                                                                                                                                                                                                                                                                                  |  |
| 8728 Liberty Road Randallstown, Md. 21133                                                                                                                |  |                                                                                                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                               |  |

01031 8 7

UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
HEADQUARTERS, ARMY  
WASHINGTON, D. C. 20315

General M. J. Dwyer



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |                                                                                                                                       |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|---------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  | 7 9 1 3 6 1 1<br>REG. NO.                                                                                                             |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Thomas E. Dorsey                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 11, 1979                                                                                     |  |  |  |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  | 4. RACE<br>White                                                                                                                      |  |  |  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>6-22-1889                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS                                                                                             |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |  |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                     |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                          |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Med. Ctr. |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Printer                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Sun Paper                                                                                        |  |  |  |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  | 13b. COUNTY<br>Baltimore                                                                                                              |  |  |  |  |
| 13c. CITY OR TOWN<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |  |  |  |
| 13e. STREET ADDRESS<br>2910 Garnett Road                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |                                                                                                                                       |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Thomas G. Dorsey                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Blanche E. Norris                                                                       |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-03-31654                                                                                              |  |  |  |  |
| 17. INFORMANT ADDRESS<br>Mildred D. Stormfeltz 2910 Garnett Rd                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |                                                                                                                                       |  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerosis cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.<br><u>4292</u><br><u>yes.</u> |  |  |  |  |                                                                                                                                       |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>COPD - Chronic GUT</u>                                                                                                                                                                                                                                                                |  |  |  |  |                                                                                                                                       |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                            |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                           |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |                                                                                                                                       |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                          |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |                                                                                                                                       |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-11-79</u> 19 <u>79</u> to <u>6-11</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-11-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                             |  |  |  |  |                                                                                                                                       |  |  |  |  |
| 22b. SIGNATURE <u>John C. Igle</u>                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  | 22c. DATE SIGNED <u>6-12-79</u>                                                                                                       |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JOHN C. Igle</u>                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  | 22e. ADDRESS<br><u>7527 Belair Ball 21236 Md</u>                                                                                      |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  | 23b. DATE<br>6-13-79                                                                                                                  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto., Balto., Md.                                                                        |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Lassahn Funeral Home                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 18 1979                                                                                          |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>L. J. Brady</u>                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |                                                                                                                                       |  |  |  |  |

11011



COPIES

1000-5000

11-3-11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHM - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR XC 21 696 608

REG. NO.

|                                                                                                                                                                                                                                                                                                                    |                                                                                                                                              |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ROY EMERSON DOTSON                                                                                                                                                                                                                                        |                                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>JUNE 24, 1979                                                                                                    |                                                                                      | 2b. HOUR<br>9:25 A.M.                                                                                                         |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                     | 4. RACE<br>BLACK                                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 22, 1896                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82                                                                                                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>11 2                                               |                                                                                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                                                                         |                                                                                      |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>V.A.M.C., FORT HOWARD, MARYLAND |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Farmer-retired                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY                                                    |                                                                                                                               |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                             | 13b. COUNTY<br>CARROLL CO.                                                                                                                   | 13c. CITY OR TOWN<br>WESTMINISTER                                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                      | 13e. STREET ADDRESS<br>1812 BLOOM ROAD                                               |                                                                                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN WESLEY DOTSON                                                                                                                                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY LOUISE GASSWAY                                                                         |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES                                                                                                                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW I                                                                              | 17. INFORMANT<br>ADDRESS<br>CLINICAL RECORD, V.A.M.C., FORT HOWARD, MD                                                                                      |                                                                                                                                                      |                                                                                      |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>496- DUE TO, OR AS A CONSEQUENCE OF<br>(b) ARTERIOSCLEROTIC VASCULAR DISEASE<br>CHRONIC OBSTRUCTIVE PULMONARY DISEASE.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                                              |                                                                                                                                                             |                                                                                                                                                      |                                                                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>MINUTES<br>YEARS                                                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                |                                                                                                                                              |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                             |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                           |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                      |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                       |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                      |                                                                                                                               |
| 22a. I certify that (this hospital) attended the deceased from JUNE 11, 1979, to JUNE 24, 1979, that (we) last saw the deceased alive on JUNE 24, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.       |                                                                                                                                              |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br>Benjamin K. Yorkoff, M.D.                                                                                                                                                                                                                                                                        |                                                                                                                                              |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                      | 22c. DATE SIGNED<br>6/24/79                                                                                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BENJAMIN YORKOFF, M.D.                                                                                                                                                                                                                                                    |                                                                                                                                              |                                                                                                                                                             | 22e. ADDRESS<br>V.A.M.C. FORT HOWARD, MARYLAND                                                                                                       |                                                                                      |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                             | 23b. DATE<br>6-27-1979                                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Fairview                                                                                                              |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Carroll, Md.                           |                                                                                                                               |
| 24. FUNERAL DIRECTOR<br>NAME Charles W. Burrier, Jr., ADDRESS Sykesville, Md.                                                                                                                                                                                                                                      |                                                                                                                                              |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR JUN 28 1979<br>25b. REGISTRAR'S SIGNATURE<br>H. H. H. H.                                                               |                                                                                      |                                                                                                                               |

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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480 | 1481 | 1482 | 1483 | 1484 | 1485 | 1486 | 1487 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                     |  |               |  |                                                                                                                                  |  |                                                                               |  |                                                                                                                                                          |  | REG. NO. 13613                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>HERBERT ALTONSO DOWELL                                                                                                                                                                                                                                                                                                                                                                           |  |               |  |                                                                                                                                  |  |                                                                               |  |                                                                                                                                                          |  | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 6 / 1 19 79 |  |
| 3. SEX Male                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE White |  | 5. DATE OF BIRTH MONTH DAY YEAR 7 / 11 / 13                                                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.                                       |  | IF UNDER 1 YR. MONTHS DAYS                                                                                                                               |  | IF UNDER 24 HRS. HOURS MIN                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va USA                                                                                                                                                                                                                                                                                                                                                                                                    |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA                                                                                                 |  |                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore                                         |  |
| 10. CITY OR TOWN OF DEATH Essex Md                                                                                                                                                                                                                                                                                                                                                                                                                     |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8214 Diamond Rd Rd 21224 |  |                                                                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Brdr. Hawk                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY GSE Co                                               |  |
| 13a. STATE Md                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |               |  | 13b. COUNTY Balto                                                                                                                |  | 13c. CITY OR TOWN Essex                                                       |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 13e. STREET ADDRESS 8214 Diamond Rd Rd 21224                                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST E A Dowell                                                                                                                                                                                                                                                                                                                                                                                                         |  |               |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy UNK                                                                              |  |                                                                               |  |                                                                                                                                                          |  |                                                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No                                                                                                                                                                                                                                                                                                                                                                                  |  |               |  | 16b. SOCIAL SECURITY NO. 240 18 7091                                                                                             |  | 17. INFORMANT HELEN DOWELL                                                    |  |                                                                                                                                                          |  | ADDRESS ABOVE                                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1619 Granulation<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } 20 - harrigan carcinoma<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                             |  |               |  |                                                                                                                                  |  |                                                                               |  |                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Wks Pgm.                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                                    |  |               |  |                                                                                                                                  |  |                                                                               |  |                                                                                                                                                          |  |                                                                                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                |  |                                                                               |  |                                                                                                                                                          |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                    |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |                                                                                                                                                          |  |                                                                                        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                        |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |                                                                                                                                                          |  |                                                                                        |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |               |  |                                                                                                                                  |  |                                                                               |  |                                                                                                                                                          |  |                                                                                        |  |
| ACTUAL SIGNATURE John C. Hyle                                                                                                                                                                                                                                                                                                                                                                                                                          |  |               |  | TITLE (SPECIFY) Dply                                                                                                             |  |                                                                               |  | DATE SIGNED 5-1-79                                                                                                                                       |  |                                                                                        |  |
| EXAMINER'S NAME (TYPE OR PRINT) JOHN C. Hyle                                                                                                                                                                                                                                                                                                                                                                                                           |  |               |  | ADDRESS 7527 Belair Rd Balto 21236                                                                                               |  |                                                                               |  |                                                                                                                                                          |  |                                                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL                                                                                                                                                                                                                                                                                                                                                                                                       |  |               |  | 23b. DATE 6/5/79                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE                               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD                                                                                                        |  |                                                                                        |  |
| 24. FUNERAL DIRECTOR NAME J. G. CONNELLY ADDRESS 300 MACE                                                                                                                                                                                                                                                                                                                                                                                              |  |               |  |                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR JUN 7 1979                                      |  | 25b. REGISTRAR'S SIGNATURE Lister H. Connelly                                                                                                            |  |                                                                                        |  |

10012



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 3 6 1 4

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 |                                                                        |                                                                                                                                                            |                                                                    |                                                                                                                                           |                                                                         |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Josephine (Bryde) Duffy</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 6, 1979</b>              |                                                                                                                                                            | 2b HOUR<br>M                                                       |                                                                                                                                           |                                                                         |                                                                                                                            |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 4 RACE<br><b>White</b>                                                                                                          |                                                                        | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 17, 1896</b>                                                                                                  |                                                                    | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>83</b>                                                                            |                                                                         | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                                                             |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Newfoundland</b>                                                                                                                                                                                                                                                                                                                           |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                    |                                                                        | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                                                                            |                                                                         |                                                                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br><b>Parkville</b>                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3324 Texas Ave.</b> |                                                                        |                                                                                                                                                            |                                                                    | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                       |                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |                                                                        |                                                                                                                                                            |                                                                    |                                                                                                                                           |                                                                         |                                                                                                                            |  |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                              |  | 13b COUNTY<br><b>Baltimore</b>                                                                                                  |                                                                        | 13c CITY OR TOWN<br><b>Parkville</b>                                                                                                                       |                                                                    | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            |                                                                         | 13e STREET ADDRESS<br><b>3324 Texas Ave.</b>                                                                               |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Whiteway</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |                                                                        | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                             |                                                                    |                                                                                                                                           |                                                                         |                                                                                                                            |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                 |                                                                        | 16b SOCIAL SECURITY NO.<br><b>217-22-4519</b>                                                                                                              |                                                                    | 17 INFORMANT<br>ADDRESS<br><b>William W. Duffy 6105 Walther Ave.</b>                                                                      |                                                                         |                                                                                                                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br><b>1991</b> |  |                                                                                                                                 |                                                                        |                                                                                                                                                            |                                                                    |                                                                                                                                           |                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                                                                                          |  |                                                                                                                                 |                                                                        |                                                                                                                                                            |                                                                    |                                                                                                                                           |                                                                         |                                                                                                                            |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            |                                                                    | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                  |  |                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            |                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                            |                                                                         |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            |                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                         |                                                                         |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                                                         |  |                                                                                                                                 |                                                                        |                                                                                                                                                            |                                                                    |                                                                                                                                           |                                                                         |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Joseph Reinhardt</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                 |                                                                        |                                                                                                                                                            |                                                                    | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                         | 22c. DATE SIGNED                                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph Reinhardt, M.D.</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |                                                                        |                                                                                                                                                            |                                                                    | 22e. ADDRESS<br><b>2003 Rock Spring Road Forest Hill, Md.</b>                                                                             |                                                                         |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                 | 23b. DATE<br><b>June 9, 1979</b>                                       |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Pk.</b> |                                                                                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |                                                                                                                            |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |                                                                        |                                                                                                                                                            |                                                                    | 25a. DATE RECEIVED BY REGISTRAR<br><b>JUN 12 1979</b>                                                                                     |                                                                         | 25b. REGISTRAR'S SIGNATURE<br><i>Richard H. Bandy</i>                                                                      |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4 1 0 1 4

(Name, etc.)

(Age)

(Sex, etc.)

|               |       |        |        |
|---------------|-------|--------|--------|
| Jan. 17, 1936 | White | U.S.A. | U.S.A. |
| Jan. 17, 1936 | White | U.S.A. | U.S.A. |
| Jan. 17, 1936 | White | U.S.A. | U.S.A. |
| Jan. 17, 1936 | White | U.S.A. | U.S.A. |
| Jan. 17, 1936 | White | U.S.A. | U.S.A. |
| Jan. 17, 1936 | White | U.S.A. | U.S.A. |
| Jan. 17, 1936 | White | U.S.A. | U.S.A. |
| Jan. 17, 1936 | White | U.S.A. | U.S.A. |
| Jan. 17, 1936 | White | U.S.A. | U.S.A. |
| Jan. 17, 1936 | White | U.S.A. | U.S.A. |

2003 Book

Joseph Belmont, etc.

Phonograph, Inc. Belmont, Maryland  
2003 Book  
Joseph Belmont, etc.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                               |                                                                                                                                 | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                             |                                                                             | 79 13615                                                                                     |                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| MAXIMILIAN A. EDER, SR                                                                                                                                                                                                                                                                                                               |                                                                                                                                 | CERTIFICATE OF DEATH                                                                                                                                     |                                                                             | REG. NO.                                                                                     |                                                                                                                         |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Maximilian A EDER</b>                                                                                                                                                                                                                                                                            |                                                                                                                                 | 2a. DATE OF DEATH MONTH DAY YEAR <b>6-24-79</b>                                                                                                          |                                                                             | 2b. HOUR <b>7PM</b>                                                                          |                                                                                                                         |
| 3. SEX <b>male</b>                                                                                                                                                                                                                                                                                                                   | 4. RACE <b>WHITE</b>                                                                                                            | 5. DATE OF BIRTH MONTH DAY YEAR <b>12 18 00</b>                                                                                                          |                                                                             | 6. AGE (IN YEARS, LAST BIRTHDAY) <b>78</b> YRS                                               |                                                                                                                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Towson Baltimore MD.</b>                             |                                                                                                                         |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Ruxton</b> |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Brewer</b> |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY <b>Beer Co.</b>                                                                       |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                           |                                                                                                                                 | 13b. COUNTY                                                                                                                                              | 13c. CITY OR TOWN <b>Baltimore</b>                                          | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS <b>718 N. Glover Street</b>                                                                         |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Maximilian Eder</b>                                                                                                                                                                                                                                                                           |                                                                                                                                 | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>                                                                                                |                                                                             |                                                                                              |                                                                                                                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                          |                                                                                                                                 | 16b. SOCIAL SECURITY NO. <b>216-05-4069</b>                                                                                                              |                                                                             | 17. INFORMANT ADDRESS <b>Maximilian A. Eder, Jr., 6504 Laurelton Ave.</b>                    |                                                                                                                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adeno carcinoma Lung</b>                                                                                                                                                                                |                                                                                                                                 |                                                                                                                                                          |                                                                             |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>                                                            |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____                                                                                                                                                                                                                                                                                        |                                                                                                                                 |                                                                                                                                                          |                                                                             |                                                                                              |                                                                                                                         |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                                                                                                              |                                                                                                                                 |                                                                                                                                                          |                                                                             |                                                                                              |                                                                                                                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                            |                                                                                                                                 |                                                                                                                                                          |                                                                             |                                                                                              |                                                                                                                         |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                             | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                   |                                                                                                                                 | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>                                                                                                   |                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |                                                                                                                         |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                               |                                                                                                                                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)                                                                                       |                                                                             | 21f. LOCATION CITY OR TOWN STREET COUNTY STATE                                               |                                                                                                                         |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6 June 79</b> to <b>24 June 79</b> , that (I) (we) last saw the deceased alive on <b>23 June 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                 |                                                                                                                                                          |                                                                             |                                                                                              |                                                                                                                         |
| 22b. SIGNATURE <b>Walter T. Kees</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                 | DEGREE <b>MD</b>                                                                                                                                         |                                                                             | 22c. DATE SIGNED <b>25 June 79</b>                                                           |                                                                                                                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER T. KEES</b>                                                                                                                                                                                                                                                                          |                                                                                                                                 | 22e. ADDRESS <b>3018 Houches Mill Rd Monkton Md</b>                                                                                                      |                                                                             |                                                                                              |                                                                                                                         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                              |                                                                                                                                 | 23b. DATE <b>June 27, 1979</b>                                                                                                                           |                                                                             | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>                                      |                                                                                                                         |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>                                                                                                                                                                                                                                                                    |                                                                                                                                 | 24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Baltimore, Maryland</b>                                                                |                                                                             | 25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>                                             |                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                 | 25b. REGISTRAR'S SIGNATURE <b>Richard M. ...</b>                                                                                                         |                                                                             |                                                                                              |                                                                                                                         |



1000

3372

PLATE 1

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13016

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                        |                                                                                                                                                            |                                                                                |                                     |                                                                      |                 |                                                                                                                                            |                  |                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | FIRST                                                                  | MIDDLE                                                                                                                                                     | LAST                                                                           | 2a DATE OF DEATH                    |                                                                      | MONTH           | DAY                                                                                                                                        | YEAR             | 2b HOUR                        |
| Carl A. Eicker                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                        |                                                                                                                                                            |                                                                                | 6 9 79                              |                                                                      |                 |                                                                                                                                            |                  | 1140 A.M.                      |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4 RACE                                                                                                    |                                                                        | 5 DATE OF BIRTH                                                                                                                                            |                                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)      |                                                                      | IF UNDER 1 YEAR |                                                                                                                                            | IF UNDER 24 HRS. |                                |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                             | White                                                                                                     |                                                                        | MONTH DAY YEAR<br>2 17 02                                                                                                                                  |                                                                                | 77 YRS                              |                                                                      | MONTHS DAYS     |                                                                                                                                            | HOURS MIN.       |                                |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                         | 7b CITIZEN OF WHAT COUNTRY?                                                                               |                                                                        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9 BALTIMORE CITY OR COUNTY OF DEATH |                                                                      |                 |                                                                                                                                            |                  |                                |
| Dortmond, Germany                                                                                                                                                                                                                                                                                                                                                                                                                                | U.S.                                                                                                      |                                                                        |                                                                                                                                                            |                                                                                | Baltimore County                    |                                                                      |                 |                                                                                                                                            | MD.              |                                |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                        | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                                                                                | 12b KIND OF BUSINESS OR INDUSTRY    |                                                                      |                 |                                                                                                                                            |                  |                                |
| Catonsville                                                                                                                                                                                                                                                                                                                                                                                                                                      | House in the Pines Catonsville                                                                            |                                                                        | Cabinet Maker                                                                                                                                              |                                                                                | Self-empl.                          |                                                                      |                 |                                                                                                                                            |                  |                                |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                        |                                                                                                                                                            | 13d INSIDE CITY LIMITS?                                                        |                                     | 13e STREET ADDRESS                                                   |                 |                                                                                                                                            |                  |                                |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                        |                                                                                                                                                            | 13b. COUNTY<br>Baltimore                                                       |                                     | 13c. CITY OR TOWN<br>Arbutus                                         |                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                  | 618 Warwick Road #21229        |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                        | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |                                                                                |                                     |                                                                      |                 |                                                                                                                                            |                  |                                |
| August Eicker                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                        | Johanna Goebel                                                                                                                                             |                                                                                |                                     |                                                                      |                 |                                                                                                                                            |                  |                                |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                 |                                                                                                                                                            | 17 INFORMANT                                                                   |                                     | ADDRESS                                                              |                 |                                                                                                                                            |                  |                                |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | 219-32-1105                                                            |                                                                                                                                                            | Hilde Eicker,                                                                  |                                     | 618 Warwick Road, 21229                                              |                 |                                                                                                                                            |                  |                                |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic CVD, advanced</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                           |                                                                        |                                                                                                                                                            |                                                                                |                                     |                                                                      |                 |                                                                                                                                            |                  |                                |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                        |                                                                                                                                                            |                                                                                |                                     |                                                                      |                 |                                                                                                                                            |                  |                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            |                                                                                |                                     | 20a. AUTOPSY?                                                        |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                                                             |                  |                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                        |                                                                                                                                                            |                                                                                |                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                  |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                         |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                     |                                                                      |                 |                                                                                                                                            |                  |                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                     |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                     |                                                                      |                 |                                                                                                                                            |                  |                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                        |                                                                                                                                                            |                                                                                |                                     |                                                                      |                 |                                                                                                                                            |                  |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/26</u> , 19 <u>65</u> , to <u>6/9</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>4/26</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, so state.)                                                                                |                                                                                                           |                                                                        |                                                                                                                                                            |                                                                                |                                     |                                                                      |                 |                                                                                                                                            |                  |                                |
| 22b. SIGNATURE OF _____                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                        |                                                                                                                                                            | DEGREE _____                                                                   |                                     |                                                                      |                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                  | 22c. DATE SIGNED <u>6/9/79</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Herbert Levickas, M.D.                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                        |                                                                                                                                                            | 22e. ADDRESS<br>5404 East Drive Balto., Md. 21227                              |                                     |                                                                      |                 |                                                                                                                                            |                  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 23b. DATE<br>06-12-79                                                  |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park                            |                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Baltimore Md. |                 |                                                                                                                                            |                  |                                |
| 24 FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                        |                                                                                                                                                            | ADDRESS<br>Balto., Md. 21229                                                   |                                     | 25a. DATE REC'D. BY REGISTRAR<br>JUN 11 1979                         |                 | 25b. REGISTRAR'S SIGNATURE<br><u>Herbert J. Leach</u>                                                                                      |                  |                                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  |                                                                                                                                                             |                                                                     |                                                                                                 |                       |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                           |  | REG. NO. 13617                                                                                                                                        |  |                                                                                                                                                             |                                                                     |                                                                                                 |                       |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>MILTON EARL EITEMILLER                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                       |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06 01 79                     |                                                                                                 | 2b. HOUR<br>8:30 P.M. |                                                                                                                            |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>WHITE                                                                                                                                      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 15, 1902                                                                                                          |                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                                      |                       | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>TOWSON MD.                                              |                       |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC 6701 N. CHARLES STREET                 |  |                                                                                                                                                             |                                                                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>EXECUTIVE                      |                       | 12b. KIND OF BUSINESS OR INDUSTRY<br>INSURANCE                                                                             |  |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br>BALTIMORE                                                                                                                              |  | 13c. CITY OR TOWN<br>TOWSON                                                                                                                                 |                                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       | 13e. STREET ADDRESS<br>7 AINTREE RD. 21204                                                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Christian John EITEMILLER                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>KATHERINE CRUETZER |                                                                                                 |                       |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>212-18-0120                                                                                                               |  | 17. INFORMANT ADDRESS<br>EDNA S. EITEMILLER 7 AINTREE RD. 21204                                                                                             |                                                                     |                                                                                                 |                       |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PERITONITIS<br>5315<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) PERFORATED GASTRIC ULCER<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 DAYS<br>10 DAYS |  |                                                                                                                                                       |  |                                                                                                                                                             |                                                                     |                                                                                                 |                       |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>CA. BLADDER WITH METASTASIS                                                                                                                                                                                                                                                               |  |                                                                                                                                                       |  |                                                                                                                                                             |                                                                     |                                                                                                 |                       |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br>05-21-79                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>PERFORATED GASTRIC ULCER                                                                          |  |                                                                                                                                                             |                                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                     |                                                                                                 |                       |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                     |                                                                                                 |                       |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 05/17, 19 79, to 06/01, 19 79, that (I) (we) last saw the deceased alive on 06/01, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                            |  |                                                                                                                                                       |  |                                                                                                                                                             |                                                                     |                                                                                                 |                       |                                                                                                                            |  |
| 22b. SIGNATURE<br>F. V. MC L BOOTH                                                                                                                                                                                                                                                                                                                                                                                               |  | DEGREE<br>B.M. B.C.H. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                                                                                             |                                                                     |                                                                                                 |                       | 22c. DATE SIGNED<br>6.1.79                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. F.V. MC L BOOTH                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |  | 22e. ADDRESS<br>GREATER BALTIMORE MEDICAL CENTER                                                                                                            |                                                                     |                                                                                                 |                       |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br>JUNE 4, 1979                                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WOODLAWN CEM.                                                                                                         |                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>WOODLAWN BALTIMORE                                |                       |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |  | ADDRESS<br>6500 YORK RD.                                                                                                                                    |                                                                     | 25a. ISSUED BY<br>JUN 5 1979                                                                    |                       |                                                                                                                            |  |

BP



WILLIAM E. CLEGG  
JANUARY 1905

WILLIAM E. CLEGG

WILLIAM E. CLEGG

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WILLIAM E. CLEGG  
JANUARY 1905

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 13618

1. FOR  
STATE  
REGISTRAR

|                                                                                                                        |                                                                                                                                                |                                                                                                                                                            |                                                                                       |                                                                                                |                                                      |
|------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><i>John J. Elgert</i>                                                            |                                                                                                                                                | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><i>June 24, 1979</i>                                                                                                 |                                                                                       | 2b HOUR<br>M<br><i>1</i>                                                                       |                                                      |
| 3: SEX<br><i>male</i>                                                                                                  | 4 RACE<br><i>white</i>                                                                                                                         | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Aug. 9, 1905</i>                                                                                                   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>73</i> YRS                                       | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS                                   |                                                      |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Penn.</i>                                                               | 7b CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                      | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. Co.</i> MD.                          |                                                                                                |                                                      |
| 10 CITY OR TOWN OF DEATH<br><i>Woodlawn</i>                                                                            | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>6416 Dogwood Rd. Balto. Co.</i> |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>electrician</i> |                                                                                                | 12b KIND OF BUSINESS OR INDUSTRY<br><i>ship yard</i> |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><i>Pa.</i> |                                                                                                                                                | 13b COUNTY<br><i>Balto.</i>                                                                                                                                | 13c CITY OR TOWN<br><i>Woodlawn</i>                                                   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS<br><i>6416 Dogwood Rd.</i>        |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>? ? elgert</i>                                                             |                                                                                                                                                | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Louise ? William</i>                                                                                    |                                                                                       |                                                                                                |                                                      |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>                                       |                                                                                                                                                | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>no</i>                                                                                        |                                                                                       | 17 INFORMANT<br>ADDRESS<br><i>Mary D. Elgert 6416 Dogwood Rd.</i>                              |                                                      |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                       |                                                                                     |                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Cardio pulmonary Arrest</i><br><i>4264</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>E16 - Right Bundle Branch Block + nonspecific repolarization abnormalities</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Sudden</i><br><i>3 wks</i> |                                                                       |                                                                                     |                                                                                                                                      |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Tuberculosis - Old.</i>                                                                                                                                                                                                                                                                                                                                                                        |                                                                       |                                                                                     |                                                                                                                                      |
| 19a DATE OF OPERATION<br><i>—</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>—</i>           | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>           | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                                      |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                 | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                                      |
| 22a I certify that (I) (this hospital) attended the deceased from <i>September</i> , 19 <i>70</i> , to <i>June 24</i> , 19 <i>79</i> , that (we) last saw the deceased alive on <i>June 24</i> , 19 <i>77</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                      |                                                                       |                                                                                     |                                                                                                                                      |
| 22b SIGNATURE<br><i>Herman Brecher, M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                       | 22c DATE SIGNED<br><i>6/26/79.</i>                                                  |                                                                                                                                      |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Herman Brecher, M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                       | 22e ADDRESS<br><i>6410 Windsor Mill Rd 21207</i>                                    |                                                                                                                                      |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>burial</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23b DATE<br><i>6/27/79</i>                                            | 23c NAME OF CEMETERY OR CREMATORY<br><i>Lorraine Pk. Cem.</i>                       | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Co. Md.</i>                                                                   |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>John J. Starsbury 6411 Windsor Mill Rd.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                       | 25a DATE REC'D. BY REGISTRAR<br><i>JUL 5 1979</i>                                   |                                                                                                                                      |

The medical examiner must be notified of a death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                 |                                                                                                |                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                            |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FREDERICK FRANK ENGEL JR.</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 24 79</b>                                          |                                                                                                                                                             |  | 2b. HOUR<br><b>4:30P M</b>                                                                                                      |  |                                                                                                                            |                                              |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>White</b>                                                                         |                                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 18, 1904</b>                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                                                                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                      |                                                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                                                             |  |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>GREATER BALTO. MEDICAL CENTER</b> |                                                                                                |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Office Mgr.</b>                                          |  | 12b. INDUSTRY<br><b>Electrical Engineering</b>                                                                             |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                 |                                                                                                |                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                            |                                              |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br><b>Baltimore</b>                                                                 |                                                                                                | 13c. CITY OR TOWN<br><b>Rodgers Forge</b>                                                                                                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  | 13e. STREET ADDRESS<br><b>219 Register Ave.</b>                                                                            |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick Frank Engel, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                 |                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna A. Otto</b>                                                                                        |  |                                                                                                                                 |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-03-3616</b>                   |                                                                                                | 17. INFORMANT<br><b>Mrs. Thelma H. Engel</b>                                                                                                                |  |                                                                                                                                 |  | ADDRESS<br><b>Same</b>                                                                                                     |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC COLON CANCER</b><br><b>1539</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                                                                                        |  |                                                                                                 |                                                                                                |                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                |                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                               |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                             |  |                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                     |                                                                                                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                  |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                         |                                                                                                                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                               |  |                                                                                                                            |                                              |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/24</b> 19 <b>79</b> , to <b>6/24</b> 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6/24</b> 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death. |  |                                                                                                 |                                                                                                |                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><i>James P. Bennett</i>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                 | DEGREE                                                                                         |                                                                                                                                                             |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                                                                                                           |                                              |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. JAMES P. BENNETT</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                 | 22c. ADDRESS<br><b>GREATER BALTO. MEDICAL CENTER<br/>6701 N. CHARLES STREET, TOWSON, 21204</b> |                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Transit-Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>June 28, 1979</b>                                                               |                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Grove</b>                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Portsmouth, Norfolk, Virginia</b>                                              |  | 23e. DATE REC'D. BY REGISTRAR                                                                                              |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | ADDRESS<br><b>6500 York Rd.<br/>Balto., Md.</b>                                                 |                                                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 28 1979</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jeffrey M. Brady</i>                                                                           |  |                                                                                                                            |                                              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                    |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                            |  | REG. NO. 13620                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John A. Engers, Sr.                                                                                                                                                                                                                                              |  |                                                                                                                                          |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 28, 1979                                            |  | 2b. HOUR<br>M                                                                                                                 |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                           |  | 4 RACE<br>White                                                                                                                          |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Apr. 23, 1895                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84                                                           |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                           |  |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>288 Bloomsbury Ave. Apt. C9 |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Arundel Corp.                                                                            |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br>Baltimore                                                                                                                 |  | 13c. CITY OR TOWN<br>Catonsville                                                                                                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>288 Bloomsbury Ave.                                                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Engers                                                                                                                                                                                                                                                |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anne Gier                                                                                                  |  |                                                                                                 |  |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW I                                                                                                                                                                                            |  |                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT<br>ADDRESS<br>415 Gun Rd.<br>Dr. John A. Engers Ellicott City                     |  |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140 Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) ASHD<br>DUE TO, OR AS A CONSEQUENCE OF (c) year                                                               |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2 seconds                                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                      |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 27, 1979, to June 28, 1979, that (I) lost saw the deceased alive on June 27, 1979, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |
| 22b. SIGNATURE<br>James Nolan MD                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  | DEGREE<br>MD                                                                                                                                                |  |                                                                                                 |  | 22c. DATE SIGNED<br>6/29/79                                                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James J. Nolan, M.D.                                                                                                                                                                                                                                           |  |                                                                                                                                          |  | 22e. ADDRESS<br>1 Mallow Hill Road                                                                                                                          |  |                                                                                                 |  |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Entombment                                                                                                                                                                                                                                              |  | 23b. DATE<br>June 30, 1979                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Maus.                                                                                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Md.                                                                                                                                                                                                                                    |  |                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                       |  |                                                                                                                               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                    |  |  |  |  |                                                                                                                            |  |  |                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                  |  |  |  |  | REG. NO. 13621                                                                                                             |  |  |                                                          |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Marshall E. Enos                                                                                                                                                                                                                                                                    |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 5, 1979                                                                           |  |  |                                                          |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                          |  |  |  |  | 4. RACE<br>White                                                                                                           |  |  |                                                          |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>May 17, 1931                                                                                                                                                                                                                                                                         |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48                                                                                      |  |  |                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                   |  |  |                                                          |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                             |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                               |  |  |                                                          |  |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                     |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>44 Wilfred Court |  |  |                                                          |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Production Worker                                                                                                                                                                                                                                      |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Noxell Co.                                                                            |  |  |                                                          |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                  |  |  |  |  | 13b. COUNTY<br>Baltimore                                                                                                   |  |  |                                                          |  |
| 13c. CITY OR TOWN<br>Towson                                                                                                                                                                                                                                                                                             |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  |                                                          |  |
| 13e. STREET ADDRESS<br>44 Wilfred Court                                                                                                                                                                                                                                                                                 |  |  |  |  |                                                                                                                            |  |  |                                                          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Richard E. Enos                                                                                                                                                                                                                                                                  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>M. Catharine Evans                                                           |  |  |                                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                 |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-28-8239                                                                                    |  |  |                                                          |  |
| 17. INFORMANT ADDRESS<br>Barbara Ann Enos, Same As #13e                                                                                                                                                                                                                                                                 |  |  |  |  |                                                                                                                            |  |  |                                                          |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) Renal failure<br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) Carcinomatosis<br>(c) Bronchiogenic carcinoma, right lung |  |  |  |  |                                                                                                                            |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 months |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                    |  |  |  |  |                                                                                                                            |  |  |                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |  |  |                                                          |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                               |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                                                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |  |  |                                                          |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                          |  |  |  |  |                                                                                                                            |  |  |                                                          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                        |  |  |                                                          |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                          |  |  |  |  |                                                                                                                            |  |  |                                                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 27, 1960, to June 5, 1979, that (I) (we) lost saw the deceased alive on June 1, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |                                                                                                                            |  |  |                                                          |  |
| 22b. SIGNATURE<br>Donald O. Wood M.D.                                                                                                                                                                                                                                                                                   |  |  |  |  | 22c. DATE SIGNED<br>6/6/79                                                                                                 |  |  |                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Donald O. Wood M. D.                                                                                                                                                                                                                                                           |  |  |  |  | 22e. ADDRESS<br>York Road & Greenmeadow Drive, Timonium, Md                                                                |  |  |                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                  |  |  |  |  | 23b. DATE<br>6-6-79                                                                                                        |  |  |                                                          |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Crematory                                                                                                                                                                                                                                                             |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                                                             |  |  |                                                          |  |
| 24. FUNERAL DIRECTOR NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204                                                                                                                                                                                                                                           |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 8 1979                                                                                |  |  |                                                          |  |
| 25b. REGISTRAR'S SIGNATURE<br>Barbara Ann Enos                                                                                                                                                                                                                                                                          |  |  |  |  |                                                                                                                            |  |  |                                                          |  |

MEDICAL CERTIFICATION

12021



*Handwritten signature or text, possibly "M. D. ..."*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |                                                                               |                                                                                                                                                             |                                                                                       |                                                                                                 |                                                                                 |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Margaret C. Ensor</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 27, 1979</b>                   |                                                                                                                                                             |                                                                                       | 2b. HOUR<br><b>3:40 PM</b>                                                                      |                                                                                 |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>White</b>                                                                                                                 |                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 29, 1903</b>                                                                                                 |                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                                               |                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           |                                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |                                                                                 |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |                                                                               |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b> |                                                                                                 |                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                       |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                         |                                                                               | 13c. CITY OR TOWN<br><b>Monkton</b>                                                                                                                         |                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                 | 13e. STREET ADDRESS<br><b>16513 Garfield Ave.</b>                                                                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lewis Chilcoat</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Wheeler</b>     |                                                                                                                                                             |                                                                                       |                                                                                                 |                                                                                 |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-74-6600</b> |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>George C. Ensor Same as #13.</b>                       |                                                                                                 |                                                                                 |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>(c) <b>VENTRICULAR TACHYCARDIA</b> |  |                                                                                                                                         |                                                                               |                                                                                                                                                             |                                                                                       |                                                                                                 |                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>DIFFUSE BRAIN DAMAGE 27 TO CARDIAC ARREST</b>                                                                                                                                                                   |  |                                                                                                                                         |                                                                               |                                                                                                                                                             |                                                                                       |                                                                                                 |                                                                                 |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |                                                                                                                                                             |                                                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                   |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |                                                                                                                                                             |                                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                                                                 |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |                                                                                                                                                             |                                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                 |                                                                                                                            |  |
| 22. I certify that neither hospital attended the deceased from June 23, 1979, to June 27, 1979, nor the deceased alive on June 27, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (Leave blank) (do not sign the body after death)                                                               |  |                                                                                                                                         |                                                                               |                                                                                                                                                             |                                                                                       |                                                                                                 |                                                                                 |                                                                                                                            |  |
| 22a. SIGNATURE<br><i>Steven Ramirez</i><br>DOCTOR                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         |                                                                               |                                                                                                                                                             |                                                                                       | 22b. ADDRESS<br><b>50 SCOTT ADAM RD<br/>COCKEYSVILLE, MD</b>                                    |                                                                                 | 22c. DATE SIGNED<br><b>6/27/79</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Rivera-Ramirez</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         |                                                                               |                                                                                                                                                             |                                                                                       |                                                                                                 |                                                                                 |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         | 23b. DATE<br><b>June 30, 1979</b>                                             |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bosley Meth. Cemetery</b>                    |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Maryland</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         | ADDRESS<br><b>Towson, Md. 21204</b>                                           |                                                                                                                                                             |                                                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 29 1979</b>                                             |                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>Richard H. ...</i>                                                                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| item 5,6 #G533 7/19/79 ph<br>FOR<br>1 - STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                            |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JEAN L. ESSON                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |  |                                                                                                                                                            |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 26, 1979                                                                                          |  | 2b. HOUR<br>M                                                                                                              |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br>White                                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 28, 1897                                                                                                           |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>81-87 YRS                                                                                                |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN                                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>England                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                                |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Manor Care - Towson |  |                                                                                                                                                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                            |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br>Baltimore                                                                                                         |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |  | 13e. STREET ADDRESS<br>1657 Burnwood Road                                                                                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James McNeill                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elizabeth Martin Stewart                                                                                     |  |                                                                                                                                            |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>076-20-7029D                                                                                         |  | 17. INFORMANT ADDRESS<br>Ella M. Loman 1657 Burnwood Road                                                                                                  |  |                                                                                                                                            |  |                                                                                                                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Congestive Heart Failure</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                  |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  |                                                                                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                    |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>12/26</u> , 19 <u>60</u> , to <u>6/26</u> , 19 <u>77</u> , that (1) (we) last saw the deceased alive on <u>6/28/77</u> , 19 <u>77</u> , and that at (my/our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                                                                  |  |                                                                                                                                  |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>William Meredith Smith</u>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                  |  | DEGREE<br><u>M.D.</u>                                                                                                                                      |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>6/27/77</u>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William Meredith Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |  | 22e. ADDRESS<br>1900 E. Northern Parkway                                                                                                                   |  |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>June 28, 1979                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood                                                                                                             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                                                              |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. 5305 Harford Rd. Balto; Md.                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 28 1979                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><u>Ruby McCreedy</u>                                                                                         |  |                                                                                                                            |  |

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |                                                             |       |                                                                               |        |                                                                     |      |                                      |                         | REG. NO. 13624                               |          |                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|-------|-------------------------------------------------------------------------------|--------|---------------------------------------------------------------------|------|--------------------------------------|-------------------------|----------------------------------------------|----------|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                             | FIRST |                                                                               | MIDDLE |                                                                     | LAST |                                      | 2d. DATE KNOWN OF DEATH |                                              | 2b. HOUR |                          |  |
| Douglas Edward EVERHART, Jr.                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                             |       |                                                                               |        |                                                                     |      |                                      | June 19, 1979 10P       |                                              | M        |                          |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE                                                     |       | 5. DATE OF BIRTH                                                              |        | 6. AGE (IN YEARS)                                                   |      | IF UNDER 1 YR.                       |                         | IF UNDER 24 HRS.                             |          | 2c. DATE PRONOUNCED DEAD |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | White                                                       |       | Dec. 30, 1944                                                                 |        | 34 YRS.                                                             |      | MONTHS                               |                         | DAYS                                         |          | 2d. HOUR                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?                                |       | 8. MARRIED                                                                    |        | NEVER MARRIED                                                       |      | 9. BALTIMORE CITY OR COUNTY OF DEATH |                         |                                              |          |                          |  |
| West Virginia                                                                                                                                                                                                                                                                                                                                                                                                                            |  | U.S.A.                                                      |       | WIDOWED                                                                       |        | DIVORCED                                                            |      | Baltimore Co.,                       |                         |                                              |          | MD.                      |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |       | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |        | 12b. KIND OF BUSINESS OR INDUSTRY                                   |      |                                      |                         |                                              |          |                          |  |
| Towson                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | St. Josephs Hospital                                        |       | Mechanic                                                                      |        | Automobile                                                          |      |                                      |                         |                                              |          |                          |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                 |       | 13c. CITY OR TOWN                                                             |        | 13d. INSIDE CITY LIMITS?                                            |      | 13e. STREET ADDRESS                  |                         |                                              |          |                          |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | Baltimore                                                   |       | 21234                                                                         |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |      | 1829 Trenleigh Road                  |                         |                                              |          |                          |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                    |       |                                                                               |        |                                                                     |      |                                      |                         |                                              |          |                          |  |
| Douglas                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | E.                                                          |       | Everhart, Sr.                                                                 |        | Julia                                                               |      | M.                                   |                         | Corbin                                       |          |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.                                    |       | 17. INFORMANT                                                                 |        | ADDRESS                                                             |      | 21234                                |                         |                                              |          |                          |  |
| Yes                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | Vietnam                                                     |       | 235-68-9097                                                                   |        | Gail K. Everhart                                                    |      | 1829 Tranleigh Rd.                   |                         |                                              |          |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9552 IMMEDIATE CAUSE (a) <u>Circumspetition from</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <u>Bullet Wound</u><br>DUE TO, OR AS A CONSEQUENCE OF<br><u>abdominal Aorta</u><br>(c) <u>Sudden</u>                                 |  |                                                             |       |                                                                               |        |                                                                     |      |                                      |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                      |  |                                                             |       |                                                                               |        |                                                                     |      |                                      |                         |                                              |          |                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |       | 20. AUTOPSY?                                                                  |        |                                                                     |      |                                      |                         |                                              |          |                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                             |       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |        |                                                                     |      |                                      |                         |                                              |          |                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY                                         |       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |        |                                                                     |      |                                      |                         |                                              |          |                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 9P June 19, 1979                                            |       | 22C, 1800 Bullet from Long Rifle                                              |        |                                                                     |      |                                      |                         |                                              |          |                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |       | 21f. LOCATION                                                                 |        |                                                                     |      |                                      |                         |                                              |          |                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | Home                                                        |       | 1829 Trenleigh Rd                                                             |        | Baltimore                                                           |      | West Va.                             |                         |                                              |          |                          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                                             |       |                                                                               |        |                                                                     |      |                                      |                         |                                              |          |                          |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                         |  | TITLE (SPECIFY)                                             |       | MEDICAL EXAMINER                                                              |        | DATE SIGNED                                                         |      |                                      |                         |                                              |          |                          |  |
| Charles F. O'Donnell                                                                                                                                                                                                                                                                                                                                                                                                                     |  | M.D. Deputy                                                 |       |                                                                               |        | 6/19/79                                                             |      |                                      |                         |                                              |          |                          |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS                                                     |       |                                                                               |        |                                                                     |      |                                      |                         |                                              |          |                          |  |
| Charles F. O'Donnell                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7501 York Rd                                                |       |                                                                               |        |                                                                     |      |                                      |                         |                                              |          |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE                                                   |       | 23c. NAME OF CEMETERY OR CREMATORY                                            |        | 23d. LOCATION                                                       |      | COUNTY                               |                         | STATE                                        |          |                          |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | June 23, 1979                                               |       | Pleasant View                                                                 |        | Martinsburg                                                         |      | West Va.                             |                         |                                              |          |                          |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR                               |       | 25b. REGISTRAR'S SIGNATURE                                                    |        |                                                                     |      |                                      |                         |                                              |          |                          |  |
| NAME                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | ADDRESS                                                     |       |                                                                               |        |                                                                     |      |                                      |                         |                                              |          |                          |  |
| William E. Johnson                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 8521 Loch Raven Blvd.                                       |       | JUN 22 1979                                                                   |        | R. J. H. H. H.                                                      |      |                                      |                         |                                              |          |                          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                |  |                                                                                                                                       |  |                                                                                                                                                            |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                 |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------|
| FOR Items 21a. - 21f. & 22a.<br>1- STATE REGISTRAR File # G533 7-12-79 as                                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |  |                                                                                                                                                            |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                 |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Francis George EVERING                                                                                                                                                                                                                                                                                     |  |                                                                                                                                       |  |                                                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 4, 1979                                     |                                                                                                                                            | 2b. HOUR a<br>3.12 M                                                                                                       |                                                                 |                                              |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br>White                                                                                                                       |  | 5. DATE OF BIRTH<br>Sept. 28, 1927                                                                                                                         |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51                                                                                                      |                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                                |                                                                                                                            |                                                                 |                                              |
| 10. CITY OR TOWN OF DEATH<br>Rossville                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |                                                                                                                                                            |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NA                                                                     |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                               |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Rossville 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 9000 Lennings Lane                                                                |  |                                                                                                                                       |  |                                                                                                                                                            |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                 |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Louis F. Evering                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Estelle A. Selling                     |                                                                                                                                            |                                                                                                                            |                                                                 |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br>216240725                                                                                                 |  | 17. INFORMANT ADDRESS<br>Margaret A. Evering 9000 Lennings La.                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                 |                                              |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrest<br>3459 DUE TO, OR AS A CONSEQUENCE OF (b) Seizure Disorder<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Post Traumatic Epilepsy |  |                                                                                                                                       |  |                                                                                                                                                            |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                                                                            |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                 |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  |                                                                                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 |                                              |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                 |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                 |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. Natural DEGREE                          |  |                                                                                                                                       |  |                                                                                                                                                            |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                 |                                              |
| 22b. SIGNATURE<br>[Signature]                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  |                                                                                                                                                            |                                                                                      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                            | 22c. DATE SIGNED<br>6-4-79                                      |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                       |  |                                                                                                                                                            |                                                                                      | 22e. ADDRESS                                                                                                                               |                                                                                                                            |                                                                 |                                              |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>6-6-79                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith                                                                                                     |                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                                                                             |                                                                                                                            |                                                                 |                                              |
| 24. FUNERAL DIRECTOR<br>[Signature]                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 7 1979                                                                                                                |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                  |                                                                                                                            |                                                                 |                                              |

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doi:10.1017/S002229240000193

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 3 6 2 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                           |                                                                                                                                                          |                                                                                      |                                                                                                 |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARCIA R. FERTITTA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                           |                                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 20, 1979</b>                          |                                                                                                 | 2b. HOUR<br><b>8:10 am</b>                                                                                                 |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE<br><b>White</b>                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 2, 1915</b>                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                                    |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD                   |                                                                                                 |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SAINT JOSEPH HOSPITAL</b> |                                                                                                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Clerical</b>                                                                       |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                           | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                          | 13c. CITY OR TOWN<br><b>Lutherville</b>                                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>45 Belmore Road</b>                                                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gaitano Rizzo</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Frances Provenzano</b>                                                                               |                                                                                      |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br><b>216-07-0865</b>                                                                                                           |                                                                                      | 17. INFORMANT<br>ADDRESS<br><b>Vincent T. Fertitta Same as #13.</b>                             |                                                                                                                            |
| <b>II CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cerebral hypoxia</b><br>410-<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF                                                                                        |                                                                                                                                           |                                                                                                                                                          |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                           |                                                                                                                                                          |                                                                                      |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                        |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 10</b> , 19 <b>79</b> , to <b>June 20</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>June 20</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death. |                                                                                                                                           |                                                                                                                                                          |                                                                                      |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><i>Lester A. Wall, Jr.</i><br>DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                           |                                                                                                                                                          |                                                                                      | 22c. DATE SIGNED<br><b>June 20, 1979</b>                                                        |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lester A. Wall, Jr., MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                           |                                                                                                                                                          |                                                                                      | 22e. ADDRESS<br><b>7620 York Road, Towson, MD 21204</b>                                         |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                           | 23b. DATE<br><b>June 23, 1979</b>                                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cem.</b>                     |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Balto., Md.</b>                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                           | ADDRESS<br><b>1050 York Road Towson, Md. 21204</b>                                                                                                       |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>                                             | 25b. REGISTRAR'S SIGNATURE<br><i>Robert A. Brady</i>                                                                       |



M

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

353

|                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                     |                                                                                                                                            |                                                                          |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Emily Pentland Feulner</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 19, 79</b>                 |                                                                                                                                                             |                                                                     | 2b. HOUR <b>6.30</b> <sup>am</sup> <sub>M</sub>                                                                                            |                                                                          |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>White</b>                                                                                                                 |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Febr. 5, 1895</b>                                                                                                  |                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                                                                          |                                                                          | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ENGLAND</b>                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                                                                            |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                                        |                                                                          |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT INSURE FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's N. Home</b> |                                                                        |                                                                                                                                                             |                                                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House wife</b>                                                      |                                                                          | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                     |                                                                                                                                            |                                                                          |                                                                                                                            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>County</b>                                                                                                            |                                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                       |                                                                          |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Pentland</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hannabelle Burlison</b>                                                                                 |                                                                     |                                                                                                                                            |                                                                          |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         |                                                                        | 16b. SOCIAL SECURITY NO.<br><b>156-40-8748</b>                                                                                                              |                                                                     | 17. INFORMANT <b>5504 N. Medwick Garth</b><br><b>Mr. John W. Faulner, Catonsville, Md. 21228</b>                                           |                                                                          |                                                                                                                            |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Gastric Carcinoma</b><br><b>1519</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                     |                                                                                                                                            |                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b>                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                     |                                                                                                                                            |                                                                          |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Chronic asthma, cachexia and anorexia</b>                                                                                                                                                                                                   |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                     |                                                                                                                                            |                                                                          |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                           |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |                                                                          |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                       |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                          |                                                                                                                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>6/18</b> , 19 <b>79</b> , to <b>6</b> , 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>6/18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                    |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                     |                                                                                                                                            |                                                                          |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>James Evans</b> DEGREE <b>MD</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                     | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                          | 22c. DATE SIGNED<br><b>6/19/79</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Evans</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                     | 22e. ADDRESS<br><b>1132 N. Rolling Rd., Catonsville, Md 21228</b>                                                                          |                                                                          |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY <b>Burial</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         | 23b. DATE<br><b>6/21/79</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b> |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>1630 Edmondson Ave. Catonsville, Md</b><br><b>Witzke Funeral Home of Catonsville, P.A. 21228</b>                                                                                                                                                                                                                                                   |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                     | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 20 1979</b>                                                                                        |                                                                          | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McSherry</i>                                                                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                                            |  |                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|---------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                    |  | REG. NO. 13628                                                                                                                       |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                                            |  |                                 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                             |  | FIRST G. ROLLAND                                                                                                                     |  | MIDDLE ROLLAND                                                                                                                                              |  | LAST FINLAYSON                                                                |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>29 79 1979                                                                          |  | 2b. HOUR<br>2203 M              |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>White                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 17, 1934                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>45 YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                          |  | 8. IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Utah                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                  |  |                                                                                                                            |  |                                 |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SAINT JOSEPH'S HOSPITAL |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Physician |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dermatology                                                                           |  |                                 |  |
| 13a. STATE Maryland                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                                            |  |                                 |  |
| 13b. COUNTY Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 13c. CITY OR TOWN Lutherville                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br>15 Pickett Road                                        |  |                                                                                                                            |  |                                 |  |
| 14. FATHER'S NAME<br>FIRST Glen MIDDLE A. LAST Finlayson                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Mina MIDDLE W. LAST Wettstin                                                                                              |  |                                                                               |  |                                                                                                                            |  |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>529-38-0518                                                                                      |  | 17. INFORMANT<br>ADDRESS<br>Carolyn L. Finlayson Same as #13.                 |  |                                                                                                                            |  |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) DISEASE<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                 |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                                            |  |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                                            |  |                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                               |  |                                                                                                                            |  |                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                               |  |                                                                                                                            |  |                                 |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 29, 1979, to June 29, 1979, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 29, 1979, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                                            |  |                                 |  |
| 22b. SIGNATURE<br>RICHARD BIGGS, M.D.                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |                                                                               |  | 22c. DATE SIGNED                                                                                                           |  |                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICHARD BIGGS, M.D.                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |  | 22e. ADDRESS                                                                                                                                                |  |                                                                               |  |                                                                                                                            |  |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>July 5, 1979                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wasath Cemetery                                                                                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Salt Lake City, Utah            |  |                                                                                                                            |  |                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      |  | ADDRESS<br>1050 York Road<br>Towson, Md. 21204                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 3 1979                                   |  | 25b. REGISTRAR'S SIGNATURE<br>Fitzpatrick                                                                                  |  |                                 |  |

8 2 2 1 2 2 8

ROBERT J. HARRIS

1922-23

Jan. 17, 1923

X

BALTIMORE COUNTY

SAINT JOSEPH'S HOSPITAL

TOWSON

Physician

X

Admission

Medical Record

Used

HYOCARDIAL INFARCTION

ARTERIOSCLEROTIC CARDIOVASCULAR  
DISEASE

1922-23

June 29

X

June 29

RICHARD BICE, M.D.

Physician

Physician

SAINT JOSEPH'S HOSPITAL, TOWSON, M.D.

1922-23



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |  | REG. NO. 13629                                                                                                                                                      |  |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                                    |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Alfonso "Alphonso" Fisher</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |  | June 24, 1979                                                                                                                                                       |  |                                                                                                                         |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4 RACE<br><b>Black</b>                                                                                                                 |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>Mar. 4, 1922</b>                                                                                                               |  | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>57 YRS</b>                                                             |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Greensboro, Pa.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                         |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>          |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                      |  |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Peabody</b>                                                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                                     |  | 13c. STREET ADDRESS<br><b>5108 Ivanhoe Avenue</b>                                                                       |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Catherine Lovejoy</b>                                                                                               |  |                                                                                                                         |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>218-18-7036</b>                                                              |  | 17. INFORMANT ADDRESS<br><b>Mrs. Alberta Fisher 5108 Ivanhoe Avenue</b>                                                                                             |  |                                                                                                                         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLE MYOCARDIAL INFARCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHEROSCLEROTIC CARDIOVASCULAR</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DISEASE, D.M., RENAL INSUFF.</b> |  |                                                                                                                                        |  |                                                                                                                                                                     |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>6/24 19 79</b>                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                      |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                      |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/24 19 79</b> to <b>6/24 19 79</b> that (b) (we) last saw the deceased alive on <b>6/24 19 79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |  |                                                                                                                                                                     |  |                                                                                                                         |  |
| 22b. SIGNATURE <b>Luis E. Rivera MD</b> DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATES SIGNED <b>6/20/79</b>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LUIS E. RIVERA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  | 22e. ADDRESS<br><b>50 SCOTT ADAMS RD</b>                                                                                                                            |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>6/28/79</b>                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>                                                                                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Arbutus, Maryland</b>                                                     |  |
| 24 FUNERAL DIRECTOR<br><b>LEROY O. DYETT &amp; SON</b> ADDRESS<br><b>4600 Liberty Hgts. Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br><i>Barney McBratney</i>                                                                   |  |



F S C C I

(M)



BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                         |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                          |  |  |  | 7 9 1 3 6 3 0<br>REG. NO.                                                                                                                                   |  |  |  |                                                                                                                               |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Eugene                                                                                                                                                                                                                                                                         |  |  |  | 3 FIRST<br>MIDDLE<br>LAST<br>Fishpaugh                                                                                                                                                                                                                                                                                                                                        |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6/14/79                                                                                                              |  |  |  | 2b. HOUR<br>12:53P M                                                                                                          |  |  |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                        |  |  |  | 4. RACE<br>White                                                                                                                                                                                                                                                                                                                                                              |  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 8, 1907                                                                                                         |  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS MIN.<br>71                                                                 |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>Maryland                                                                                                                                                                                                                                                          |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                                                                        |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC, 6701 N. Charles St. 21204                                                                                                                                                                                                                                  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer                                                                                 |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Steel                                                                                 |  |  |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                               |  |  |  | 13b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                                                                                      |  |  |  | 13c. CITY OR TOWN<br>21093                                                                                                                                  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Thomas Fishpaugh                                                                                                                                                                                                                                                    |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret                                                                                                                                                                                                                                                                                                                      |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                  |  |  |  | 16b. SOCIAL SECURITY NO.<br>218-03-2745                                                                                       |  |  |  |
| 17 INFORMANT<br>ADDRESS<br>21234                                                                                                                                                                                                                                                                                     |  |  |  | 18.1 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                                                             |  |  |  |                                                                                                                               |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.                                                                                                                                                                                   |  |  |  |                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |                                                                                                                                                             |  |  |  |                                                                                                                               |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                               |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                              |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                             |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                                                                    |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |  |  |                                                                                                                               |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                         |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                        |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |  |  |                                                                                                                               |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/14/79 19 to 6/14/79 19, that (I) (we) last<br>saw the deceased alive on 6/14/79 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |                                                                                                                                                             |  |  |  |                                                                                                                               |  |  |  |
| 22b. SIGNATURE<br>S. P. Girdhar                                                                                                                                                                                                                                                                                      |  |  |  | DEGREE                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED<br>6/14/79                                                                                                   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. P. Girdhar, M.D.                                                                                                                                                                                                                                                         |  |  |  | 22e. ADDRESS<br>GBMC, 6701 N. Charles St. 21204                                                                                                                                                                                                                                                                                                                               |  |  |  |                                                                                                                                                             |  |  |  |                                                                                                                               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                            |  |  |  | 23b. DATE<br>June 15, '79                                                                                                                                                                                                                                                                                                                                                     |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Park Balto. Co., Md.                                                                                    |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                    |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>William E. Johnson                                                                                                                                                                                                                                                                    |  |  |  | ADDRESS<br>8521 Loch Raven Blvd.                                                                                                                                                                                                                                                                                                                                              |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 18 1979                                                                                                                |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                     |  |  |  |

U S C S

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                        |  |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                     |  | REG. NO. 13631                                                                                         |  |                                                                                                                                                         |  |                                                                                                                        |  |                                              |  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                            |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                  |  | LAST                                                                                                                   |  | 2a DATE OF DEATH MONTH DAY YEAR              |  |
| GRACE                                                                                                                                                                                                                                                                                                      |  | E                                                                                                      |  | FLANAGAN                                                                                                                                                |  | 6                                                                                                                      |  | 11 79                                        |  |
| 3 SEX                                                                                                                                                                                                                                                                                                      |  | 4 RACE                                                                                                 |  | 5 DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                                         |  | 7b HOUR                                      |  |
| Female                                                                                                                                                                                                                                                                                                     |  | White                                                                                                  |  | Nov. 5, 1908                                                                                                                                            |  | 70                                                                                                                     |  | 9:20A                                        |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                   |  | 7b CITIZEN OF WHAT COUNTRY?                                                                            |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |  | 10b UNDER 24 HRS. MONTHS DAYS HOURS MIN.     |  |
| Md.                                                                                                                                                                                                                                                                                                        |  | USA                                                                                                    |  |                                                                                                                                                         |  | BALTIMORE CITY COUNTY                                                                                                  |  |                                              |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                                       |  |                                              |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                  |  | GREATER BALTO. MED. CENTER                                                                             |  | Ret. Secretary                                                                                                                                          |  |                                                                                                                        |  |                                              |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                |  | 13b COUNTY                                                                                             |  | 13c CITY OR TOWN                                                                                                                                        |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e STREET ADDRESS                           |  |
| Md.                                                                                                                                                                                                                                                                                                        |  | Baltimore                                                                                              |  | Glen Arm                                                                                                                                                |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                    |  | 11837 Glen Arm Road                          |  |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b SOCIAL SECURITY NO.                                                                                                |  | 17 INFORMANT ADDRESS                         |  |
| John O. Evans                                                                                                                                                                                                                                                                                              |  | Rosa Markley                                                                                           |  | no                                                                                                                                                      |  | 215-07-3383                                                                                                            |  | Mr. George M. Flanagan Jr. 3419 Hamilton Ave |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                    |  | 19                                                                                                     |  | 20                                                                                                                                                      |  | 21                                                                                                                     |  | 22                                           |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)                                                                                                                                                                                                                                                            |  | RESPIRATORY FAILURE                                                                                    |  |                                                                                                                                                         |  |                                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 1629                                                                                                                                                                                                                                                                                                       |  | DUE TO, OR AS A CONSEQUENCE OF                                                                         |  | TERMINAL CA                                                                                                                                             |  |                                                                                                                        |  |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                              |  | DUE TO, OR AS A CONSEQUENCE OF                                                                         |  | INOPERABLE CA OF LUNG                                                                                                                                   |  |                                                                                                                        |  |                                              |  |
| (c)                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                        |  |                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                        |  |                                              |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                      |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                        |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                          |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                    |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                        |  |                                              |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                      |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                        |  |                                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from 6/11 1979 to 6/11 1979, that (I) (we) last saw the deceased alive on 6/11 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b SIGNATURE                                                                                          |  | DEGREE                                                                                                                                                  |  | 22c DATE SIGNED                                                                                                        |  |                                              |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                       |  | 22e ADDRESS                                                                                            |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                         |  |                                                                                                                        |  |                                              |  |
| POLLAECCHI, Louis                                                                                                                                                                                                                                                                                          |  | GBMC 6701 N CHARLES ST. BALTO. MD.                                                                     |  |                                                                                                                                                         |  |                                                                                                                        |  |                                              |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                   |  | 23b DATE                                                                                               |  | 23c NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d LOCATION CITY OR TOWN COUNTY STATE                                                                                 |  |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                     |  | June 14, 1979                                                                                          |  | New Cathedral                                                                                                                                           |  | Baltimore Md.                                                                                                          |  |                                              |  |
| 24 FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                   |  | 24b ADDRESS                                                                                            |  | 25a DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b REGISTRAR'S SIGNATURE                                                                                              |  |                                              |  |
| Leonard J. Ruck Inc. Baltimore, Maryland                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | JUN 12 1979                                                                                                                                             |  | L. J. Ruck                                                                                                             |  |                                              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                            |                                                                                                 |                                                                                      |                                                                                                                            |                                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                       |  | 7 9                                                                                                                                          |  | 1 3 6 3 2                                                                                                                                                  |                                                                                                 | REG. NO.                                                                             |                                                                                                                            |                                                                  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>EDITH H. FLINN</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  |                                                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 5, 1979</b>                                         |                                                                                      |                                                                                                                            | 2b. HOUR<br><b>1:05 P.M.</b>                                     |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 4 RACE<br><b>WHITE</b>                                                                                                                       |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>10 09 98</b>                                                                                                          |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                                    |                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Baltimore County</b> MD.            |                                                                                                                            |                                                                  |  |
| 10 CITY OR TOWN OF DEATH<br><b>ESSEX</b>                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |  |                                                                                                                                                            |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Lansdowne</b>                                                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                      | 13e. STREET ADDRESS<br><b>105 Ridge Avenue, 21227</b>                                                                      |                                                                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Austin Shock</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Unknown</b>                                    |                                                                                      |                                                                                                                            |                                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br><b>218-44-3684</b>                                                                                               |  | 17 INFORMANT ADDRESS<br><b>Glen Burnie, Md.<br/>LaRue Merson, 5808 Elkins Street 21061</b>                                                                 |                                                                                                 |                                                                                      |                                                                                                                            |                                                                  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>4292 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b><br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                              |  |                                                                                                                                                            |                                                                                                 |                                                                                      |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a.<br><b>Status post cerebrovascular accident; adult onset diabetes mellitus</b>                                                                                                                                                                                |  |                                                                                                                                              |  |                                                                                                                                                            |                                                                                                 |                                                                                      |                                                                                                                            |                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                             |  |                                                                                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |                                                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |                                                                                                 |                                                                                      |                                                                                                                            |                                                                  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>June 4</b> , 19 <b>79</b> , to <b>June 5</b> , 19 <b>79</b> , that (we) lost saw the deceased alive on <b>June 5</b> , 19 <b>79</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. <b>X</b>                                   |  |                                                                                                                                              |  |                                                                                                                                                            |                                                                                                 |                                                                                      |                                                                                                                            |                                                                  |  |
| 22b. SIGNATURE<br><b>Barbara Parey</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | DEGREE<br><b>MD</b>                                                                                                                                        |                                                                                                 |                                                                                      |                                                                                                                            | 22c. DATE SIGNED<br><b>6-5-79</b>                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Barbara Parey MD</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr. 21237</b>                                                                                                      |                                                                                                 |                                                                                      |                                                                                                                            |                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>06-08-79</b>                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. JOHN'S EPISCOPAL</b>                                                                                          |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELLICOTT CITY HOWARD MD.</b>        |                                                                                                                            |                                                                  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 6 1979</b>                                                                                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |                                                                                                                            |                                                                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                      |  | REG. NO. 13633                                                                                                                                              |  |                                                                                                                         |                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                      |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                            |  |                                                                                                                         |                                                           |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary B. Fogarty                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                      |  | 2b. HOUR 4:50 P.M.                                                                                                                                          |  |                                                                                                                         |                                                           |
| 3. SEX Female                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE White                                                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 6, 1901                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.                                                                                 |                                                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY? USA                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.                                                               |                                                           |
| 10. CITY OR TOWN OF DEATH Towson                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Maryland Care, Inc. Towson<br>504 E. Joppa Rd. Balt #1204 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ins. Clerk                                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY USF & G                                                                               |                                                           |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Balto.                                                                                                                                                                                                                                                         |  |                                                                                                                      |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  |                                                                                                                         |                                                           |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Brennan                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ann Augusta Hiss                                                                                              |  |                                                                                                                         |                                                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO 213 20 4200                                                                                  |  | 17. INFORMANT ADDRESS James J. Fogarty III Finksburg, Md.                                                                                                   |  |                                                                                                                         |                                                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Failure</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>acute atherosclerotic Cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>other</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 1/2 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                |  |                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                         |                                                           |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                     |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |                                                           |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |                                                           |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1978, to 1978, that (I) (we) lost saw the deceased alive on 1978, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                 |  |                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                         |                                                           |
| 22b. SIGNATURE <u>Walter T. Kees</u> DEGREE <u>MD</u>                                                                                                                                                                                                                                                                                                                                                              |  | 22c. DATE SIGNED                                                                                                     |  |                                                                                                                                                             |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADDRESS<br>WALTER T. KEES 3018 Houghs Mill Rd Monkton Md 21091                    |                                                           |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE 6-25-79                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral                                                                                                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                                               |                                                           |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR JUN 25 1979                                                                                                                   |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>                                                                           |                                                           |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph Frank FOLKER Jr.                                                                                                                                                                                                                                                                                               |  |                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 20 79                         |                                                                                                                                                             |                                                                                | 2b. HOUR a<br>7:30 M                                                                                                                                 |                                                                                                 |                                                                                                                            |                                               |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>CAUCASIAN                                                                                                                  |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 16 00                                                                                                              |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS                                                                                                            |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                   |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                                         |                                                                                                 |                                                                                                                            |                                               |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CAR INSPECTOR                                                                    |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>PENN. RR CO.                                                                          |                                               |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       | 13b. CITY OR TOWN<br>BALTIMORE                                         |                                                                                                                                                             | 13c. CITY OR TOWN<br>ROSEDALE                                                  |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br>8501 DAYTONA RD. 21237 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH FOLKER                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>THERESA               |                                                                                                                                                             |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>717077252    |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>CATHERINE FOLKER 8501 DAYTONA RD.                  |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Respiratory Arrest<br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Carcinoma of Lung<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |                                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                           |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                     |  |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                    |  |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/11/1979 to 6/20/1979, that (I) (we) last saw the deceased alive on 6/20/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                  |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                               |  |
| 22b. SIGNATURE<br>Lisa Chow M.D.                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br>6/20/79                                                                                                |                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lisa Chow, M.D.                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                       | 22e. ADDRESS<br>9000 Franklin Square Drive                             |                                                                                                                                                             |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       | 23b. DATE<br>6/23/79                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL                            |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.                                        |                                                                                                                            |                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John J. Wach                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       | ADDRESS<br>1211 Chesaco Ave.                                           |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 25 1979                                   |                                                                                                                                                      | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                       |                                                                                                                            |                                               |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                              |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                      |  | 7 9 1 3 6 3 5<br>REG. NO.                                                                                                         |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>EMERAL E. FORD                                                                                     |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>JUNE 17 79                                       |  | 2b. HOUR<br>M                                                                                                              |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>W                                                                                                                      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 23 97                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS                                            |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. COUNTY MD.                            |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>ESSEX                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4418 MARBLE HALL RD. |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RET.             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SALESMAN                                                                              |  |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |  | 13b. COUNTY<br>BALTO.                                                                                                                                       |  | 13c. CITY OR TOWN<br>ESSEX                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LINK                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LINK                                                                                                       |  |                                                                                      |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWI                                                                    |  | 17. INFORMANT<br>ADDRESS<br>MARGARET PIOTROWSKI 100 COVERED WAGON RD.                                                                                       |  |                                                                                      |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140 Coronary heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Atherosclerotic CVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 yrs<br>Decades                                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                               |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br>—                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                                                                             |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. — 19                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>—                                                                         |  |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                      |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-8, 19 76, to 4-25, 19 79, that (I) (we) last saw the deceased alive on 4-16, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                 |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Sidney Scherlis M.D.                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |                                                                                      |  | 22c. DATE SIGNED<br>6-20-79                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sidney Scherlis, M.D.                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                   |  | 22e. ADDRESS<br>8415 Bellona Ln. #217 Towson, Md.                                                                                                           |  |                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br>6/20/79                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MORELAND MEM. PK.                                                                                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ESSEX BALTO. MD.                       |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 26 1979                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>CONNELLY F.H.                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                   |  | ADDRESS<br>300 MACE AVE                                                                                                                                     |  | 25b. REGISTRAR'S SIGNATURE<br>Piotrowski                                             |  |                                                                                                                            |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

REG. NO.

1 3 6 3 6

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |                                          |                                                                                                                                                          |  |                                                                       |  |                                                                                              |  |                                                                                                                         |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Sr. Sister Mary Vianney Forgeng</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        | 2a. DATE OF DEATH MONTH DAY YEAR 6 29 79 |                                                                                                                                                          |  | 2b. HOUR 2:13 P                                                       |  |                                                                                              |  |                                                                                                                         |  |  |  |
| 3 SEX Female                                                                                                                                                                                                                                                                                                                                                                |  | 4 RACE White                                                                                                                           |                                          | 5. DATE OF BIRTH MONTH DAY YEAR 2 14 99                                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 80                                    |  | 7. IF UNDER 1 YEAR MONTHS DAYS                                                               |  | 8. IF UNDER 24 HRS. HOURS MIN.                                                                                          |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                                    |                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.             |  |                                                                                              |  |                                                                                                                         |  |  |  |
| 10. CITY OR TOWN OF DEATH Glen Arm                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa Maria, 11630 Glen Arm Rd. |                                          |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher |  | 12b. KIND OF BUSINESS OR INDUSTRY Education                                                  |  |                                                                                                                         |  |  |  |
| 13a. STATE Maryland                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                          | 13b. COUNTY Baltimore                                                                                                                                    |  | 13c. CITY OR TOWN Glen Arm                                            |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS 11630 Glen Arm Road                                                                                 |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Valentine Forgeng                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |                                          | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine                                                                                                     |  |                                                                       |  |                                                                                              |  |                                                                                                                         |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |                                          | 16b. SOCIAL SECURITY NO. 143-42-4808                                                                                                                     |  | 17. INFORMANT ADDRESS T Sister Mary Grau same                         |  |                                                                                              |  |                                                                                                                         |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>old age</u> <u>Cardiopulm Arrest</u><br>4392 DUE TO, OR AS A CONSEQUENCE OF <u>ASCVD</u><br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>old age</u><br>(c) <u>old age</u>                                                          |  |                                                                                                                                        |                                          |                                                                                                                                                          |  |                                                                       |  |                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>IMMEDIATE<br>YEARS                                                      |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                             |  |                                                                                                                                        |                                          |                                                                                                                                                          |  |                                                                       |  |                                                                                              |  |                                                                                                                         |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  |                                                                       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                          |  |                                                                                                                                        |                                          | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                     |  |                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |                                                                                                                         |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |                                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  |                                                                       |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                         |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>78</u> , to <u>6/29/79</u> , 19 <u>79</u> , that <u>(w)</u> lost saw the deceased alive on <u>June 29</u> , 19 <u>79</u> , and that <u>(my)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(w)</u> did <u>not</u> view the body after death. |  |                                                                                                                                        |                                          |                                                                                                                                                          |  |                                                                       |  |                                                                                              |  |                                                                                                                         |  |  |  |
| 22b. SIGNATURE <u>Lawrence Boas</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                                       |  |                                                                                                                                        |                                          |                                                                                                                                                          |  |                                                                       |  | 22c. DATE SIGNED <u>July 1, 79</u>                                                           |  |                                                                                                                         |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lawrence Boas, M. D.                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        |                                          |                                                                                                                                                          |  |                                                                       |  | 22e. ADDRESS 21030 50 Scott Adam Road, Cockeysville, Md.                                     |  |                                                                                                                         |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                          | 23b. DATE 7-1-79                                                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY Sisters Cemetery                   |  |                                                                                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Arm, Balto., Md.                                                           |  |  |  |
| 24. FUNERAL DIRECTOR Curran Funeral Home ADDRESS 308 High Street Cambridge, Maryland DATE REC'D. BY REGISTRAR 7/6 1979 REGISTRAR'S SIGNATURE <u>History McCready</u>                                                                                                                                                                                                        |  |                                                                                                                                        |                                          |                                                                                                                                                          |  |                                                                       |  |                                                                                              |  |                                                                                                                         |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                  |                                                                                                                                |                                                                                                                                                             |                                                                                              |                                                                                                                                                      | REG. NO. 13637                                |                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH                                                                            |                                                                                                                                                      | 2b. HOUR                                      |                                                                                                                                    |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>TESSIE M. FOWIKES                                                                                                                                                                                                                                                                                               |                                                                                                                                |                                                                                                                                                             | JUNE 22 1979                                                                                 |                                                                                                                                                      | 8:00 AM                                       |                                                                                                                                    |
| 3 SEX<br>F                                                                                                                                                                                                                                                                                                                                                            | 4 RACE<br>CAUCASIAN                                                                                                            | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 7 94                                                                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)<br>84                                                         |                                                                                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.     |                                                                                                                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. VA.                                                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CO. MD.                                       |                                                                                                                                                      |                                               |                                                                                                                                    |
| 10. CITY OR TOWN OF DEATH<br>BALTO. CO.                                                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>823 SILVER CREEK RD. |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                   |                                                                                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETIRED. |                                                                                                                                    |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD. 13b. COUNTY BALTO. 13c. CITY OR TOWN                                                                                                                                                                                                                        |                                                                                                                                |                                                                                                                                                             | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                                      | 13e. STREET ADDRESS<br>823 SILVER CREEK RD.   |                                                                                                                                    |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>WM. KIDDY                                                                                                                                                                                                                                                                                                                      |                                                                                                                                |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY JANE SHARP                                |                                                                                                                                                      |                                               |                                                                                                                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                               |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>236-03-5623                                                                                                                     |                                                                                              | 17. INFORMANT ADDRESS<br>JANE TIERNEY 823 SILVER CREEK RD. 21201                                                                                     |                                               |                                                                                                                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410 - ACUTE MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE ATHEROSCLEROSIS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) DUE TO, OR AS A CONSEQUENCE OF |                                                                                                                                |                                                                                                                                                             |                                                                                              |                                                                                                                                                      |                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                   |                                                                                                                                |                                                                                                                                                             |                                                                                              |                                                                                                                                                      |                                               |                                                                                                                                    |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                    |                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |                                                                                                                                | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                        |                                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                               |                                                                                                                                    |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                |                                                                                                                                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |                                                                                              | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                       |                                               |                                                                                                                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 71 to JUNE 22 19 79, that (I) (we) lost saw the deceased alive on JUNE 17 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                       |                                                                                                                                |                                                                                                                                                             |                                                                                              |                                                                                                                                                      |                                               |                                                                                                                                    |
| 22b. SIGNATURE<br>M. M. MENENDEZ, M.D.                                                                                                                                                                                                                                                                                                                                |                                                                                                                                |                                                                                                                                                             |                                                                                              | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                               | 22c. DATE SIGNED<br>6-22-79                                                                                                        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARCO M. MENENDEZ, MD.                                                                                                                                                                                                                                                                                                       |                                                                                                                                |                                                                                                                                                             |                                                                                              | 22e. ADDRESS<br>5820 YORK ROAD - BALTO. MD 21201                                                                                                     |                                               |                                                                                                                                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                   |                                                                                                                                | 23b. DATE<br>6-26-79                                                                                                                                        |                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br>HEAVENERS CEM.                                                                                                 |                                               | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>UPSHUR CO. W. VA.                                                                       |
| 24. FUNERAL DIRECTOR NAME<br>NEWELL F.H.                                                                                                                                                                                                                                                                                                                              |                                                                                                                                |                                                                                                                                                             |                                                                                              | ADDRESS<br>1100 REISTERSTOWN RD                                                                                                                      |                                               | 25a. DATE REC'D. BY REGISTRAR<br>JUN 25 1979                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                |                                                                                                                                                             |                                                                                              |                                                                                                                                                      |                                               | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                          |

BP

13031

DATE 1/11/50

FOCUS

TEST

CONCERN IS 11 1/4

FACTS

CHARTERED BY THE BOARD OF DIRECTORS

TO BE USED FOR THE PURPOSES OF THE COMPANY

AND TO BE KEPT IN THE OFFICE OF THE SECRETARY

UNTIL THE BOARD OF DIRECTORS SHALL ORDER OTHERWISE

IN WRITING

ATTEST

SECRETARY

DATE 1/11/50

BY

THE BOARD OF DIRECTORS

AT THE ANNUAL MEETING

HELD AT THE COMPANY'S OFFICE

ON JANUARY 11, 1950

AT NEW YORK, NEW YORK

IN WITNESS WHEREOF



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs in the hospital, the certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                     |  | REG. NO. 13638                                                                                         |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                            |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                  |  | LAST                                                                                         |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                        |  | 2b. HOUR                                     |  |
| ANITA E. GAILEY                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  | 6 4 79                                                                                                                  |  | 4:55 P.                                      |  |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                                      |  | 4 RACE                                                                                                 |  | 5 DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                               |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |  | IF UNDER 7a HRS MIN.                         |  |
| F                                                                                                                                                                                                                                                                                                                                                                                          |  | Caucasian                                                                                              |  | 11 28 01                                                                                                                                                |  | 77                                                                                           |  |                                                                                                                         |  |                                              |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                   |  | 7b CITIZEN OF WHAT COUNTRY?                                                                            |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                          |  |                                                                                                                         |  |                                              |  |
| PENNSYLVANIA                                                                                                                                                                                                                                                                                                                                                                               |  | U.S.A.                                                                                                 |  |                                                                                                                                                         |  | BALTIMORE COUNTY MD.                                                                         |  |                                                                                                                         |  |                                              |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                         |  |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| TOWSON                                                                                                                                                                                                                                                                                                                                                                                     |  | G.B.M.C.                                                                                               |  |                                                                                                                                                         |  |                                                                                              |  | HOUSEWIFE                                                                                                               |  |                                              |  |
| 13a STATE                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b COUNTY                                                                                             |  | 13c CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS                                                                                                      |  |                                              |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                   |  | BALTIMORE                                                                                              |  | TOWSON                                                                                                                                                  |  |                                                                                              |  | 204 EAST JOPPA ROAD                                                                                                     |  |                                              |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                              |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| FRANK KUICH                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  | MARY NORTHAMER                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                           |  | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                                                    |  | 17. INFORMANT ADDRESS                                                                                                                                   |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| NO                                                                                                                                                                                                                                                                                                                                                                                         |  | 179-20-8566                                                                                            |  | C. CLARKE GAILEY, 204 E. JOPPA RD., TOWSON, MD.                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410 -                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">             DUE TO, OR AS A CONSEQUENCE OF<br/> <b>CARDIOGENIC SHOCK</b> </div> <div style="width: 45%;">             DUE TO, OR AS A CONSEQUENCE OF<br/> <b>ANTERIOR LATERAL M.I.</b> </div> </div> |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                            |  | P.M. 19                                                                                                |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/27 19 79 to 6/4 19 79, that (I) (we) last saw the deceased alive on 6/4 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                               |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | DEGREE                                                                                                                                                  |  |                                                                                              |  | 22c. DATE SIGNED                                                                                                        |  |                                              |  |
| STEPHEN LAIKEN, M.D.                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  | 6/4/79                                                                                                                  |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | 22e. ADDRESS                                                                                                                                            |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| STEPHEN LAIKEN, M.D.                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  | 6701 N. CHARLES STREET 21204                                                                                                                            |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                      |  |                                                                                                                         |  |                                              |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                     |  | JUNE 7, 1979                                                                                           |  | SLATE RIDGE CEMETERY                                                                                                                                    |  | DELTA, YORK COUNTY, PA.                                                                      |  |                                                                                                                         |  |                                              |  |
| 24 FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | ADDRESS                                                                                                                                                 |  |                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR                                                                                           |  | 25b. REGISTRAR'S SIGNATURE                   |  |
| JOHN H. HARKINS                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | 600 MAIN ST., DELTA, PA.                                                                                                                                |  |                                                                                              |  | JUN 11 1979                                                                                                             |  | [Signature]                                  |  |

BP



SEATTLE COUNTY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13639

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                          |                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Paul Hawkins Gantt</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 7 1979</b> |                                                                                                                                                             | 2b. HOUR<br><b>12:10 a.m.</b>                                                  |                                                                                                                                          |                                                                                             |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>White</b>                                                                                                            |                                                        | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 26, 1907</b>                                                                                                    |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS                                                                                         |                                                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Vienna, Austria</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                    |                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                                      |                                                                                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>302 E. Joppa Road</b> |                                                        |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lawyer</b> |                                                                                                                                          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Federal Govt. FEDERAL GOV'T.</b>                    |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |                                                        | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                             |                                                                                | 13c. CITY OR TOWN<br><b>Towson</b>                                                                                                       |                                                                                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Henry Gans</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    |                                                        | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Olga Ochs</b>                                                                                              |                                                                                |                                                                                                                                          |                                                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><b>228-14-3938</b>                                                                                     |                                                        | 17. INFORMANT ADDRESS<br><b>Hilda D. Gantt, Same As #13e</b>                                                                                                |                                                                                |                                                                                                                                          |                                                                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br><b>Coronary Occlusion</b><br>IMMEDIATE CAUSE (a) <b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Chronic obstructive lung disease</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic obstructive lung disease</b> |  |                                                                                                                                    |                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>a few minutes</b><br><b>over 5 years</b> |  |
| 19a. DATE OF OPERATION<br><b>none</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>---</b>                                                                     |                                                        | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>                                                          |                                                                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |                                                                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                          |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>no injury</b>                                                          |                                                                                |                                                                                                                                          |                                                                                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |                                                        | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                                |                                                                                                                                          |                                                                                             |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>August 7</b> , 19 <b>78</b> , to <b>June 6th</b> , 19 <b>79</b> , that (I) (we) saw the deceased alive on <b>May 17</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                             |  |                                                                                                                                    |                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                          |                                                                                             |  |
| 22b. SIGNATURE<br><b>Charles E. Ellicott M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | DEGREE                                                                                                                             |                                                        | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                                                                                | 22c. DATE SIGNED<br><b>June 7 '79</b>                                                                                                    |                                                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles E. Ellicott, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 22e. ADDRESS<br><b>1134 York Road Lutherville MD 21204</b>                                                                         |                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                          |                                                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>6-9-79</b>                                                                                                         |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>                                                                                         |                                                                                | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                                                                    |                                                                                             |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Ruck Towson Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | ADDRESS<br><b>Towson, Md. 21204</b>                                                                                                |                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 8 1979</b>                                                                                                          |                                                                                | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey M. Brady</b>                                                                                    |                                                                                             |  |

1 2 3 4 5 6 7



TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                       |  |                                                                     |  |                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                |  | 7 9 1 3 6 4 0                                                       |  | REG. NO.                                                                                               |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                      |  | FIRST MIDDLE LAST                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                       |  |
| Mary Veronica Gardner                                                                                                                                                                                                                                                                                 |  |                                                                     |  | 6 30 79                                                                                                |  |
| 3. SEX                                                                                                                                                                                                                                                                                                |  | 4. RACE                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                        |  |
| Female                                                                                                                                                                                                                                                                                                |  | White                                                               |  | 9 18 04                                                                                                |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                                                                                                                                                                                       |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                            |  | 8. IF UNDER 1 YEAR MONTHS DAYS                                                                         |  |
| 74 YRS.                                                                                                                                                                                                                                                                                               |  | Maryland                                                            |  | MONTHS DAYS                                                                                            |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                                                                                                                                                                  |  | 10. CITY OR TOWN OF DEATH                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |
| Baltimore County MD.                                                                                                                                                                                                                                                                                  |  | Dundalk                                                             |  | 2709 Gray Manor Terrace                                                                                |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  | 13a. STREET ADDRESS                                                                                    |  |
| Housewife                                                                                                                                                                                                                                                                                             |  |                                                                     |  | 2709 Gray Manor Terrace                                                                                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                      |  |
| Frank Fisher                                                                                                                                                                                                                                                                                          |  | Frances Studzinski                                                  |  | No                                                                                                     |  |
| 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                              |  | 17. INFORMANT                                                       |  | ADDRESS                                                                                                |  |
| 216-10-3932                                                                                                                                                                                                                                                                                           |  | Albert Gardner                                                      |  | 8104 Kavanagh Rd. Balto. MD 21222                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                             |  |                                                                     |  |                                                                                                        |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                          |  |                                                                     |  |                                                                                                        |  |
| IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC HEART DISEASE                                                                                                                                                                                                                                                   |  |                                                                     |  |                                                                                                        |  |
| 4140 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                   |  |                                                                     |  |                                                                                                        |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                    |  |                                                                     |  |                                                                                                        |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                    |  |                                                                     |  |                                                                                                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                   |  |                                                                     |  |                                                                                                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?                                                                                          |  |
|                                                                                                                                                                                                                                                                                                       |  |                                                                     |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |  |
|                                                                                                                                                                                                                                                                                                       |  | P.M. 19                                                             |  |                                                                                                        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION CITY OR TOWN COUNTY STATE                                                                |  |
|                                                                                                                                                                                                                                                                                                       |  |                                                                     |  |                                                                                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-30-79 to 6-30-79, that (I) (we) last saw the deceased alive on 6-10-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                     |  |                                                                                                        |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                        |  | DEGREE                                                              |  | 22c. DATE SIGNED                                                                                       |  |
| Francis T. Duda                                                                                                                                                                                                                                                                                       |  | MD                                                                  |  | 7/3/79                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                 |  | 22e. ADDRESS                                                        |  |                                                                                                        |  |
| Francis T. Duda                                                                                                                                                                                                                                                                                       |  | 4300 N. Charles St.                                                 |  |                                                                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                             |  | 23b. DATE                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                     |  |
| Burial                                                                                                                                                                                                                                                                                                |  | 7/5/79                                                              |  | Holly Hill Mem.                                                                                        |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                               |  | 23e. DATE REC'D. BY REGISTRAR                                       |  | 23f. REGISTRAR'S SIGNATURE                                                                             |  |
| White Marsh, Balto. MD                                                                                                                                                                                                                                                                                |  | JUL 5 1979                                                          |  | Anthony McBrady                                                                                        |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                             |  | 24b. ADDRESS                                                        |  | 24c. DATE REC'D. BY REGISTRAR                                                                          |  |
| Duda-Ruck, Inc.                                                                                                                                                                                                                                                                                       |  | 7922 Wise Avenue, Dundalk, MD 21222                                 |  | JUL 5 1979                                                                                             |  |

U P C C I C A



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                        |  |                                                                                                                                  |  | 79 13641                                                                                     |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|----------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |  | REG. NO.                                                                                     |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MARY CAROL GARRETT                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>6-27-79                                                  |                                              |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>White                                                                                                                 |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 12, 1934                                             |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>45 YRS.                            |                                              |
| 10. CITY OR TOWN OF DEATH<br>Catonsville                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Spring Grove Hosp Ctr. |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.                                    |                                              |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—                                                       |                                              |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |  | 13b. COUNTY<br>Balto.                                                                        |                                              |
| 13c. CITY OR TOWN<br>Randallstown                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 13e. STREET ADDRESS<br>2906 Ridge Rd.                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                  |  |                                                                                              |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>CARROLL E. Cofell, Sr.                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Annabel L. Ensor                               |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                                                                                                                                                                                                                                                                                        |  |                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>215-32-2771                                                      |                                              |
| 17. INFORMANT ADDRESS<br>Michael McKenzie 2906 Ridge Rd. Balto, Md. 21207                                                                                                                                                                                                                                                                                   |  |                                                                                                                                  |  |                                                                                              |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ca of the Colon</u><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                  |  |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                        |  |                                                                                                                                  |  |                                                                                              |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                              |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                     |  |                                                                                                                                  |  |                                                                                              |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |                                                                                                                                  |  |                                                                                              |                                              |
| 22b. SIGNATURE<br>Phillip Deza, M.D.                                                                                                                                                                                                                                                                                                                        |  | DEGREE                                                                                                                           |  | 22c. DATE SIGNED<br>6-27-79                                                                  |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Phillip Deza, M.D.                                                                                                                                                                                                                                                                                                 |  | 22e. ADDRESS<br>SPRING GROVE HOSPITAL CENTER<br>Catonsville, Maryland 21228                                                      |  |                                                                                              |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>June 29, 1979                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Black Rock Cem.                                        |                                              |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Butler, Balto Co, Md.                                                                                                                                                                                                                                                                                            |  |                                                                                                                                  |  |                                                                                              |                                              |
| 24. FUNERAL DIRECTOR NAME<br>H.G. Schlueth                                                                                                                                                                                                                                                                                                                  |  | ADDRESS<br>Owings Mills                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                                                  |                                              |
| 25b. REGISTRAR'S SIGNATURE<br>H.T. Eckhardt                                                                                                                                                                                                                                                                                                                 |  | 25c. REGISTRAR'S SIGNATURE<br>H.T. Eckhardt                                                                                      |  |                                                                                              |                                              |

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(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                                               |                                                                |                                   |              |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------|--------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                               |                                                                                                                                            |                                                               | 3. REG. NO.                                                    |                                   |              |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                            |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                               |                                                                                                                                            |                                                               | 3. REG. NO.                                                    |                                   |              |                                              |
| SHIRLEY A. GARTRELL                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        | 6 18 79                                                                                                                                                  |                                                               |                                                                                                                                            |                                                               | 1 3 6 4 2                                                      |                                   |              |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                               |                                                                                                                                            | 7. IF UNDER 1 YEAR                                            |                                                                | 8. IF UNDER 24 HRS                |              | 9. BALTIMORE CITY OR COUNTY OF DEATH         |
| FEMALE                                                                                                                                                                                                                                                                                                                                                                      | CAUC                                                                                                   | 2/11/28                                                                                                                                                  | 51                                                            |                                                                                                                                            | MONTHS                                                        |                                                                | DAYS                              |              | BALTIMORE COUNTY                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                                                                                                                                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                | 12b. KIND OF BUSINESS OR INDUSTRY |              |                                              |
| MD.                                                                                                                                                                                                                                                                                                                                                                         | U.S.                                                                                                   |                                                                                                                                                          | BALTIMORE COUNTY                                              |                                                                                                                                            | SALES                                                         |                                                                | HECHT CO.                         |              |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                             |                                                                |                                   |              |                                              |
| TOWSON, MD.                                                                                                                                                                                                                                                                                                                                                                 | GBMC-6701 N. CHARLES ST.                                                                               |                                                                                                                                                          | SALES                                                         |                                                                                                                                            | HECHT CO.                                                     |                                                                |                                   |              |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 13b. COUNTY                                                                                                                                              | 13c. CITY OR TOWN                                             | 13d. INSIDE CITY LIMITS?                                                                                                                   | 13e. STREET ADDRESS                                           |                                                                |                                   |              |                                              |
| MD.                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        | BALTO.                                                                                                                                                   | BALTO.                                                        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        | 2510 SOUTHERN AVE.                                            |                                                                |                                   |              |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                               |                                                                                                                                            |                                                               |                                                                |                                   |              |                                              |
| ARTHUR F. KOME                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        | SARAH P.                                                                                                                                                 |                                                               |                                                                                                                                            |                                                               |                                                                |                                   |              |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                           |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                                               | 17. INFORMANT                                                                                                                              |                                                               | ADDRESS                                                        |                                   |              |                                              |
| NO                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        | 220-24-5629                                                                                                                                              |                                                               | KENNETH GARTRELL                                                                                                                           |                                                               | SAME                                                           |                                   |              |                                              |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY: <b>METASTATIC CARCINOMA OF PANCREAS</b><br>IMMEDIATE CAUSE (a) <b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                                               |                                                                |                                   |              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                                               |                                                                |                                   |              |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                               | 20a. AUTOPSY?                                                                                                                              |                                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |              |                                              |
|                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                               | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |              |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                          |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                               |                                                                |                                   |              |                                              |
|                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        | P.M. 19                                                                                                                                                  |                                                               |                                                                                                                                            |                                                               |                                                                |                                   |              |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                      |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                               | 21f. LOCATION                                                                                                                              |                                                               | CITY OR TOWN                                                   |                                   | COUNTY       | STATE                                        |
|                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                                               |                                                                |                                   |              |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-5</b> , 19 <b>79</b> , to <b>6-18</b> , 19 <b>79</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>6-18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                                               |                                                                |                                   |              |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        | DEGREE                                                                                                                                                   |                                                               | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                               | 22c. DATE SIGNED                                               |                                   |              |                                              |
| <b>J. WOLF</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                                                                            |                                                               | <b>6/18/79</b>                                                 |                                   |              |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                               |                                                                                                                                            |                                                               |                                                                |                                   |              |                                              |
| <b>J. WOLF, M.D.</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        | <b>GBMC-6701 N. CHARLES ST.</b>                                                                                                                          |                                                               |                                                                                                                                            |                                                               |                                                                |                                   |              |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | 23b. DATE                                                                                                                                                |                                                               | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                         |                                                               | 23d. LOCATION                                                  |                                   | CITY OR TOWN | COUNTY                                       |
| <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        | <b>6/21/79</b>                                                                                                                                           |                                                               | <b>CORRAINE PK.</b>                                                                                                                        |                                                               | <b>BALTO, MD.</b>                                              |                                   |              |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | 24b. ADDRESS                                                                                                                                             |                                                               | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |                                                               | 25b. REGISTRAR'S SIGNATURE                                     |                                   |              |                                              |
| <b>Carl E. Chenoweth</b>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | <b>3617 Eastview Ave.</b>                                                                                                                                |                                                               | <b>JUN 19 1979</b>                                                                                                                         |                                                               | <b>Anthony McCready</b>                                        |                                   |              |                                              |

MEDICAL CERTIFICATION



SHIRLEY

GARTRELL

BALTIMORE COUNTY

TOWSON, MD. 11 GENCO-5701 . CHARLES ST.

METASTATIC CARCINOMA OF PANCREAS

8-18-73 2-3-73 8-18-73

GENCO-5701 N. CHARLES ST.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **13643**

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                         |                       |                                                                                                                                       |  |                                                     |  |                                                                                                                                                             |                          |                               |  |                                                                                                           |  |                                                                                     |                                              |                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|-----------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                         | FIRST<br><b>David</b> |                                                                                                                                       |  | MIDDLE<br><b>B.</b>                                 |  |                                                                                                                                                             | LAST<br><b>GASTOMSKI</b> |                               |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>6 12 79</b> |  |                                                                                     | 2b. HOUR<br><b>1:05 P</b>                    |                                               |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>white</b> |                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 5 70</b>                                                                                   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>9</b> YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                               |                          | IF UNDER 24 HRS.<br>HOURS MIN |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>6 12 79</b>                                              |  |                                                                                     | 1:05 P                                       |                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                         |                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                         |  |                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          |                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                                           |  |                                                                                     |                                              |                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                         |                       | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>56 Lycett Circle</b> |  |                                                     |  |                                                                                                                                                             |                          |                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SCHOOL BOY</b>                        |  |                                                                                     |                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b> |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                         |                       | 13b. COUNTY<br><b>BALTO</b>                                                                                                           |  |                                                     |  | 13c. CITY OR TOWN<br><b>ESSEX</b>                                                                                                                           |                          |                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 13e. STREET ADDRESS<br><b>56 LYCETT CIRCLE</b>                                      |                                              |                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ERNEST CHAVIS</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                         |                       |                                                                                                                                       |  |                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSEMARY P. GOSTOMSKI</b>                                                                               |                          |                               |  |                                                                                                           |  |                                                                                     |                                              |                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                         |                       | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>—</b>                                                                   |  |                                                     |  | 17. INFORMANT ADDRESS<br><b>JOHN KILLIAN 6725 AVERILL RD.</b>                                                                                               |                          |                               |  |                                                                                                           |  |                                                                                     |                                              |                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple stabwounds</b><br><b>966-</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                 |  |                         |                       |                                                                                                                                       |  |                                                     |  |                                                                                                                                                             |                          |                               |  |                                                                                                           |  |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                                    |  |                         |                       |                                                                                                                                       |  |                                                     |  |                                                                                                                                                             |                          |                               |  |                                                                                                           |  |                                                                                     |                                              |                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                     |  |                                                     |  |                                                                                                                                                             |                          |                               |  |                                                                                                           |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |                                               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                         |  |                         |                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 6 12 79</b>                                                              |  |                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>stabbed by assailant</b>                                                |                          |                               |  |                                                                                                           |  |                                                                                     |                                              |                                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                   |  |                         |                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>                                                            |  |                                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>56 Lycett Circle Baltimore, Maryland</b>                                                            |                          |                               |  |                                                                                                           |  |                                                                                     |                                              |                                               |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |                       |                                                                                                                                       |  |                                                     |  |                                                                                                                                                             |                          |                               |  |                                                                                                           |  |                                                                                     |                                              |                                               |  |
| ACTUAL SIGNATURE<br><b>Margarita A. Korell</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                         |                       | M.D. <b>Assistant</b>                                                                                                                 |  |                                                     |  | MEDICAL EXAMINER                                                                                                                                            |                          |                               |  | DATE SIGNED <b>6/13/79</b>                                                                                |  |                                                                                     |                                              |                                               |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                         |                       | ADDRESS <b>111 Penn Street</b>                                                                                                        |  |                                                     |  |                                                                                                                                                             |                          |                               |  |                                                                                                           |  |                                                                                     |                                              |                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                         |                       | 23b. DATE<br><b>6/15/79</b>                                                                                                           |  |                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN</b>                                                                                                       |                          |                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ESSEX BALTO MD.</b>                                      |  |                                                                                     |                                              |                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>CONNELLY F.H. 300 MACE AVE</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                         |                       |                                                                                                                                       |  |                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>                                                                                                         |                          |                               |  | 25b. REGISTRAR'S SIGNATURE<br><b>Dorothy McCready</b>                                                     |  |                                                                                     |                                              |                                               |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                               |  |                                                                                                                                         |                                                |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  | REG. NO. 9 13644                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>AOAM J. GEHRING                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 29 79 |                                                                                                                                                              |  | 2b. HOUR<br>8 A.M.                                                                              |  |                                                                                                                            |  |                                              |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>WHITE                                                                                                                        |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 5 1885                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94 YRS.                                                      |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |  | 8. IF UNDER 24 HRS.                          |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                              |  | 9b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                     |                                                | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |                                                                                                                            |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LITTLE SISTERS OF THE POOR |                                                |                                                                                                                                                              |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Hosiery Buyer               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |                                              |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                                                             |                                                | 13c. CITY OR TOWN<br>Baltimore                                                                                                                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1005 E. Belyedere Avenue                                                                            |  |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN GEHRING                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         |                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY A. METZ                                                                                                |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>216-01-1935                                                                                                 |                                                | 17. INFORMANT ADDRESS<br>Sr. LORETTO 601 MAIDEN CHOICE LANE                                                                                                  |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Renal failure</u><br>586-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Advanced senility and senile</u><br>(c) <u>deterioration. Advanced chronic senile</u>     |  |                                                                                                                                         |                                                |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                 |  |                                                                                                                                         |                                                |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |                                                |                                                                                                                                                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                               |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>73</u> , to <u>6-29</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                         |                                                |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 22b. SIGNATURE<br><u>Stanley Anagnost</u>                                                                                                                                                                                                                                                                                                                          |  | DEGREE<br>M.D.                                                                                                                          |                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |                                                                                                 |  | 22c. DATE SIGNED<br>6-29-79                                                                                                |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>1101 Maiden Choice La                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS<br>1101 Maiden Choice La                                                                                                   |                                                |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>Jul 2 1979                                                                                                                 |                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cemetery                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |                                                                                                                            |  |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Leonard J. Ruck, Inc. Baltimore, Maryland                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |                                                | 25a. DATE REC'D. BY REGISTRAR<br>JUL 3 1979                                                                                                                  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                |  |                                                                                                                            |  |                                              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                      |  | 7 9 1 3 6 4 5<br>REG. NO.                                                                                                             |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Roland Charles GEORGE                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 29, 1979                                    |  | 2b. HOUR<br>4:15P M                                                                                                        |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>White                                                                                                                      |  | 5. DATE OF BIRTH<br>FEB. 28, 1902                                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS                                            |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>BALTO. MD.                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Brick Layer         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired                                                                               |  |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |  |                                                                                                                                                             |  | 13b. COUNTY                                                                          |  | 13c. CITY OR TOWN<br>Balto.                                                                                                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles W. George                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mamie Murphy                           |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>215-07-3759                                                                                               |  | 17. INFORMANT ADDRESS<br>Mr. LeGrand R. George - 4427 Forest View Ave. 21206                                                                                |  |                                                                                      |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory arrest<br>1629 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Metastatic carcinoma of lung<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br>Congestive heart failure; Left cerebrovascular accident                                                                                                                                                                             |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                      |  |                                                                                                                            |  |
| 22a. I certify that X (this hospital) attended the deceased from June 17, 19 79, to June 29, 19 79, that X (we) last saw the deceased alive on June 29, 19 79, and that in X (our) opinion death occurred on the date and hour and from the causes stated above. (X we) (did) (did not) view the body after death.                                                          |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Barbara Parey MD                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                      |  | 22c. DATE SIGNED<br>6-29-79                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Barbara Parey MD                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |  | 22e. ADDRESS<br>9000 Franklin Square Dr, 21237                                                                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br>7-2-79                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cem.                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                             |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME John C. Miller Inc-6415 Belair Rd.-21206 ADDRESS                                                                                                                                                                                                                                                                                               |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JUL 5 1979 Henry McCurdy                                                                        |  |                                                                                      |  |                                                                                                                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 3 6 4 6

REG. NO.

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

JOSEPH

H.

GHEE

2a. DATE OF DEATH

MONTH

DAY

YEAR

JUNE 11, 1979

2b. HOUR

8:30 PM

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
6 20 1896

6. AGE (IN YEARS LAST BIRTHDAY)

82

YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS

HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

N.Y.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE COUNTY

MD.

10. CITY OR TOWN OF DEATH

TOWSON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
SAINT JOSEPH HOSPITAL

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)  
Ret Mgr

12b. KIND OF BUSINESS OR INDUSTRY

Finance

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

13c. CITY OR TOWN

Balto

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

1766 Weston Ave

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Ghee

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Margaret

unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

WW1 Yes

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

WW1

17. INFORMANT

216 05 5502 A

17. INFORMANT

M. Louise Stricker

ADDRESS

Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral vascular occlusion

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

170K

4292

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic CV Disease

152W

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that X (this hospital) attended the deceased from June 2, 1979, to June 11, 1979, that X (we) last

saw the deceased alive on June 11, 1979, and that in X (our) opinion death occurred on the date and hour and from the causes stated

above. X (we) (did) (not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

FREDERICK J VOLLMER

6100 York Rd 21212

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b. DATE

6/14/1979

23c. NAME OF CEMETERY OR CREMATORY

Dulaney Valley Cent.

23d. LOCATION

CITY OR TOWN

Cockeysville

COUNTY

Balto

STATE

Md.

24. FUNERAL DIRECTOR

NAME

ADDRESS

Mitchell-Wiedefeld Home 6500 York Rd.

25a. DATE RECEIVED BY REGISTRAR

JUN 15 1979

25b. RECEIVED BY REGISTRAR

JUN 15 1979





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 3 6 4 7

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                               |                                                                                                                                            |                                                                            |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>VIRGINIA G. GIACOMO</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 29, 1979</b>               |                                                                                                                                                            |                                                               | 2b. HOUR<br><b>7:30 P</b>                                                                                                                  |                                                                            |                                                                                                                            |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4 RACE<br><b>White</b>                                                                                                                  |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 16, 1913</b>                                                                                                 |                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS                                                                                            |                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS                                                                |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |                                                                        | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                                                                        |                                                                            |                                                                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |                                                                        |                                                                                                                                                            |                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                       |                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                               |                                                                                                                                            |                                                                            |                                                                                                                            |  |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 13b COUNTY<br><b>Baltimore</b>                                                                                                          |                                                                        | 13c CITY OR TOWN<br><b>21234</b>                                                                                                                           |                                                               | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                             |                                                                            | 13e STREET ADDRESS<br><b>1829 Wildwood Ave.</b>                                                                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Martin J. Gaynor</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         |                                                                        | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret G. Murphy</b>                                                                                  |                                                               |                                                                                                                                            |                                                                            |                                                                                                                            |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         |                                                                        | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-----</b>                                                                                     |                                                               | 17 INFORMANT ADDRESS<br><b>Jane V. Koehler 8706 Cimarron Circle</b>                                                                        |                                                                            |                                                                                                                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>chronic obstructive pulmonary disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>5 year</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 min</u> |  |                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                               |                                                                                                                                            |                                                                            |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                               |                                                                                                                                            |                                                                            |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            |                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                            |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            |                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                            |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 4, 1966</u> to <u>Mar 3, 1977</u> , that (I) (we) lost<br>saw the deceased alive on <u>Mar 3, 1977</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                         |  |                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                               |                                                                                                                                            |                                                                            |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>L. L. O'Leary</u><br>DEGREE <u>MD.</u>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                               | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                            | 22c. DATE SIGNED<br><u>Jun 30 '79</u>                                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>SAMUEL O'MARSKY</u>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                               | 22e. ADDRESS<br><u>1405A LOCH RAVEN BLVD.</u>                                                                                              |                                                                            |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         | 23b. DATE<br><b>7/2/79</b>                                             |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b> |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Md.</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson 8521 Loch Raven Bd.</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                               | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 2 1979</b>                                                                                         |                                                                            | 25b. REGISTRAR'S SIGNATURE<br><u>Robert McBrady</u>                                                                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1 2 3 4 5

05:2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                       |  |                                                                                                                                  |  | REG. NO. 9 1 3 6 4 8                                                                                                                                        |  |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR                                                                                                                   |  |                                                                                                                         |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Lottie Pearl Gill                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  | June 5 1979 6:25 M                                                                                                                                          |  |                                                                                                                         |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>White                                                                                                                 |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug. 12 1890                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Randallstown, Balt. MD.                                                         |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Chapel Hill Conv. Home |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bookkeeper                                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Store                                                                              |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                          |  |                                                                                                                                  |  | 13b. COUNTY<br>Balt.                                                                                                                                        |  | 13c. CITY OR TOWN<br>Rand.                                                                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Joshua                                                                                                                                                                                                                                                              |  |                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Isabel Ryan                                                                                                   |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>578-05-0884                                                                                          |  | 17. INFORMANT ADDRESS<br>M. Powell, Jr. 3692 Lyndale Rd. Reisterstown, Md.                                                                                  |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CORONARY OCCLUSION<br>410- DUE TO, OR AS A CONSEQUENCE OF H.C.V.D. 5 YRS.<br>(b) DUE TO, OR AS A CONSEQUENCE OF ASCVD 15 YRS.<br>(c)                                      |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                        |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1970 to 6-5 1979, that (I) (we) lost saw the deceased alive on 6-5 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 22b. SIGNATURE<br>P. V. Hoyer, Jr.                                                                                                                                                                                                                                                                         |  |                                                                                                                                  |  | DEGREE<br>M.D.                                                                                                                                              |  | 22c. DATE SIGNED<br>6-5-79                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>P. V. Hoyer, Jr.                                                                                                                                                                                                                                                  |  |                                                                                                                                  |  | 22e. ADDRESS<br>6500 PANORAMA DR. SYKESVILLE, MD.                                                                                                           |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                        |  | 23b. DATE<br>6-8-79                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Kempford Baptist Cemetery                                                                                             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Lynch Baltimore Md.                                                          |  |
| 24. FUNERAL DIRECTOR NAME<br>Harry W. Haight                                                                                                                                                                                                                                                               |  |                                                                                                                                  |  | ADDRESS<br>Lynchville, Md.                                                                                                                                  |  | 25a. DATE OF RECORD BY REGISTRY<br>JUN 11 1979                                                                          |  |

8 4 0 3 1 1 1 1

OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JEANNETTE STERN GOODMAN</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                             |  |                                                                                                                                                            |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FRIDAY, 6 22, 1979</b>                                   |  | 2b. HOUR P M<br><b>5:15 P M</b>                                                                                            |  |
| 3 SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 4 RACE<br><b>WHITE</b>                                                                                                                      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG. 3, 1890</b>                                                                                                  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.                                                |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                             |  |                                                                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br><b>PIKESVILLE</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PIKESVILLE NURSING HOME</b> |  |                                                                                                                                                            |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                                                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>                                                                                                                                                                                                                                 |  |                                                                                                                                             |  |                                                                                                                                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>#21209 6314 GREENSPRING AVE., APT. 101</b>                                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SIGMUND STERN</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY DANIEL</b>                                                                                        |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br><b>214-74-6999</b>                                                                                              |  | 17. INFORMANT ADDRESS<br><b>MRS. WILLIAM J. ROSENTHAL 8207 CRANWOOD CT. #21208</b>                                                                         |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro Vascular accident</b><br><b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                             |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |  |                                                                                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/18</b> to <b>6/18</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/18</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                         |  |                                                                                                                                             |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Goelombeck</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                             |  | DEGREE                                                                                                                                                     |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>6/23/79</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. LEONARD GOLOMBECK</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |  | 22e. ADDRESS<br><b>5400 OLD COURT RD.</b>                                                                                                                  |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>6-24-79</b>                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW CONG</b>                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 27 1979</b>                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McBrady</b>                                            |  |                                                                                                                            |  |
| 6010 REISTERSTOWN RD., BALTO., MD 21215                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                             |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |

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As of 10/1/77  
Change Volume Account

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10/1/77

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                     |  |                                                                                                                                                             |                                                              |                                                                                   |                                                                   |                                                                                                                         |                                                                                              |                                           |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------|--|
| FOR<br>1 - STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                     |  |                                                                                                                                                             | REG. NO. 9 13650                                             |                                                                                   |                                                                   |                                                                                                                         |                                                                                              |                                           |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Lawrence Earle Gore                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                     |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 2 1979              |                                                                                   |                                                                   |                                                                                                                         |                                                                                              | 2b. HOUR<br>6:00 PM                       |  |
| 3. SEX<br>m                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>w                                                                                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 12 1900                                                                                                                |                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.                                        |                                                                   | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                          |                                                                                              | IF UNDER 24 HRS.<br>HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. Co. MD.                             |                                                                   |                                                                                                                         |                                                                                              |                                           |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Chapel Hill Conv. Center Randallstown Md. |  |                                                                                                                                                             |                                                              | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chemical Work    |                                                                   |                                                                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY<br>Oil                                                     |                                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                                                              |  |                                                                                                                                                     |  |                                                                                                                                                             | 13b. COUNTY<br>CARROLL                                       |                                                                                   | 13c. CITY OR TOWN<br>Finksburg                                    |                                                                                                                         | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Harry Henry Gore                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                     |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Katie Musgrave |                                                                                   |                                                                   |                                                                                                                         |                                                                                              |                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>217-03-6140                                                                                                             |  | 17. INFORMANT ADDRESS<br>Lawrence K. Gore 6404 Hillcrest Rd. Sykesville, Md.                                                                                |                                                              |                                                                                   |                                                                   |                                                                                                                         |                                                                                              |                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 Arteriosclerotic C.V. Disease - Chronic<br>(b) Dysphasic Heart Failure - Chronic<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Years |  |                                                                                                                                                     |  |                                                                                                                                                             |                                                              |                                                                                   |                                                                   |                                                                                                                         |                                                                                              |                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                       |  |                                                                                                                                                     |  |                                                                                                                                                             |                                                              |                                                                                   |                                                                   |                                                                                                                         |                                                                                              |                                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                    |  |                                                                                                                                                             |                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                              |                                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                              |                                                                                   |                                                                   |                                                                                                                         |                                                                                              |                                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                              |                                                                                   |                                                                   |                                                                                                                         |                                                                                              |                                           |  |
| 22a. I certify that (I) (the hospital) attended the deceased from April 12, 1977, to June 2, 1979, that (I) (we) last saw the deceased alive on June 1, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                    |  |                                                                                                                                                     |  |                                                                                                                                                             |                                                              |                                                                                   |                                                                   |                                                                                                                         |                                                                                              |                                           |  |
| 22b. SIGNATURE<br>C.E. McWilliams                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                     |  | DEGREE<br>MD                                                                                                                                                |                                                              |                                                                                   |                                                                   | 22c. DATE SIGNED<br>6-2-79                                                                                              |                                                                                              |                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C.E. McWilliams                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                     |  | 22e. ADDRESS<br>11904 Reisterstown Rd Reisterstown Md 21136                                                                                                 |                                                              |                                                                                   |                                                                   |                                                                                                                         |                                                                                              |                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br>June 5, 1979                                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br>All Saints Cemetery                                                                                                   |                                                              |                                                                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Reisterstown Balt. Md. |                                                                                                                         |                                                                                              |                                           |  |
| 24. FUNERAL DIRECTOR NAME<br>A.J. Schhardt                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                     |  | ADDRESS<br>Owings Mills, Md.                                                                                                                                |                                                              |                                                                                   |                                                                   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 5 1979                                                                             |                                                                                              | 25b. REGISTRAR'S SIGNATURE<br>[Signature] |  |



00001

MADE IN U.S.A.  
U.S. DEPARTMENT OF COMMERCE  
BUREAU OF STANDARDS



U.S. DEPARTMENT OF COMMERCE  
BUREAU OF STANDARDS

JUN 2 1979

MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------------------------|--|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                    |  | XC 11 660 231                                                                                          |  | 7 9 1 3 6 5 1                                                                                                                                            |  | REG. NO.                                                            |  |                                                                |  |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | FIRST MIDDLE LAST                                                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR                                    |  |                                                                |  | 2b. HOUR                                     |
| CARLYLE A. GRAHAM JR.                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  | JUNE 19, 1979                                                       |  |                                                                |  | 11:15P <sub>M</sub>                          |
| 3. SEX                                                                                                                                                                                                                                                                                                    |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR MONTHS DAYS                                    |  | IF UNDER 24 HRS. HOURS MIN.                  |
| MALE                                                                                                                                                                                                                                                                                                      |  | WHITE                                                                                                  |  | 01 MONTH 06 DAY 24 YEAR                                                                                                                                  |  | 55                                                                  |  |                                                                |  |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN)                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                |  |                                              |
| MARYLAND                                                                                                                                                                                                                                                                                                  |  | U.S.A.                                                                                                 |  |                                                                                                                                                          |  | BALTIMORE COUNTY MD.                                                |  |                                                                |  |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                                              |
| FORT HOWARD                                                                                                                                                                                                                                                                                               |  | V.A.M.C., FORT HOWARD, MARYLAND                                                                        |  |                                                                                                                                                          |  | TRUCK DRIVER                                                        |  | MONARCH                                                        |  |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                                            |  |                                              |
| 13a. STATE MARYLAND 13b. COUNTY ANNE ARUNDEL 13c. CITY OR TOWN GAMBRIILLS                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | RT. 1, BOX 70D                                                 |  |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                       |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                               |  |                                                                     |  |                                                                |  |                                              |
| CARLYLE A. GRAHAM SR.                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | IRENE SHANKS                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                                                   |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                             |  |                                                                |  |                                              |
| YES                                                                                                                                                                                                                                                                                                       |  | WW II                                                                                                  |  | 217 14 5272                                                                                                                                              |  | ROBERT A. GRAHAM, 575 RIVERSIDE DRIVE FT. LAUDERDALE, FLA.          |  |                                                                |  |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |
| 5722 DUE TO, OR AS A CONSEQUENCE OF (b) HEPATIC COMA: ELECTROLYTE IMBALANCE                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |
| STATUS POST CARDIOPULMONARY RESUSCITATION                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                          |  | 20a. AUTOPSY?                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                              |
|                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                     |  |                                                                |  |                                              |
|                                                                                                                                                                                                                                                                                                           |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET                                                                                                                                     |  | CITY OR TOWN                                                        |  | COUNTY                                                         |  | STATE                                        |
|                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |
| 22a. I certify that (this hospital) attended the deceased from JUNE 19 1979, to JUNE 19 1979, that (we) last saw the deceased alive on JUNE 19 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                            |  | DEGREE                                                                                                 |  |                                                                                                                                                          |  | 22c. DATE SIGNED                                                    |  |                                                                |  |                                              |
| V. CLAUD, M. D.                                                                                                                                                                                                                                                                                           |  | MD                                                                                                     |  |                                                                                                                                                          |  | 6/20/79                                                             |  |                                                                |  |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |
| V. CLAUD, M. D.                                                                                                                                                                                                                                                                                           |  | V. A. MEDICAL CENTER, Fort Howard, MD                                                                  |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                 |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN                                          |  | COUNTY                                                         |  | STATE                                        |
| BURIAL                                                                                                                                                                                                                                                                                                    |  | 06-25-79                                                                                               |  | CHELTENHAM                                                                                                                                               |  | CHELTENHAM                                                          |  | P.G.                                                           |  | MARYLAND                                     |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                 |  | ADDRESS                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | REGISTRAR'S SIGNATURE                                               |  |                                                                |  |                                              |
| HUBBARD FUNERAL HOME, INC.,                                                                                                                                                                                                                                                                               |  | 4107 WILKENS AVE.                                                                                      |  | 21229                                                                                                                                                    |  | JUN 22 1979                                                         |  |                                                                |  |                                              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                               |  |                                                                                                                            |  |                                                                                                                                                            |  |                                                                                              |  |                                                                                                                         |                     | REG. NO. 13652                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                             |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary F. GRAY                                                         |  |                                                                                                                                                            |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 4, 1979                                             |  |                                                                                                                         | 2b. HOUR<br>1:45P M |                                             |  |
| 3 SEX<br>F                                                                                                                                                                                                                                                                                                                                         |  | 4 RACE<br>W                                                                                                                |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>April 12 1891                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.                                                   |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |                     | IF UNDER 24 HRS. HOURS MIN.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                        |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                  |  |                                                                                                                         |                     |                                             |  |
| 10 CITY OR TOWN OF DEATH<br>Rossville                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Sq Hosp |  |                                                                                                                                                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housekeeper                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>At Home                                                                            |                     |                                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY<br>Md BALTO                                                                                                                                                                                                                              |  |                                                                                                                            |  | 13b. CITY OR TOWN<br>BALTO                                                                                                                                 |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS<br>40 Robin Hood Rd Box 765                                                                         |                     |                                             |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Edward GRAY                                                                                                                                                                                                                                                                                                  |  |                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY MAINSTER                                                                                                |  |                                                                                              |  |                                                                                                                         |                     |                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>218-12-84940                                                                                   |  | 17 INFORMANT ADDRESS<br>LYNWOOD GRAY 9121 LAMAZE Rd                                                                                                        |  |                                                                                              |  |                                                                                                                         |                     |                                             |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4939 Respiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary disease and<br>DUE TO, OR AS A CONSEQUENCE OF (c) asthmatic bronchitis<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                            |  |                                                                                                                                                            |  |                                                                                              |  |                                                                                                                         |                     |                                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Aortic stenosis                                                                                                                                                                                              |  |                                                                                                                            |  |                                                                                                                                                            |  |                                                                                              |  |                                                                                                                         |                     |                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |  |                                                                                                                                                            |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                     |                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                              |  |                                                                                                                         |                     |                                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                             |  |                                                                                              |  |                                                                                                                         |                     |                                             |  |
| 22a. I certify that (X) (this hospital) attended the deceased from May 9 19 79 to June 4 19 79, that (X) (we) last saw the deceased alive on June 4 19 79, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.                                 |  |                                                                                                                            |  |                                                                                                                                                            |  |                                                                                              |  |                                                                                                                         |                     |                                             |  |
| 22b. SIGNATURE<br>Barbara Parey                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                            |  | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |                                                                                              |  | 22c. DATE SIGNED<br>6-4-79                                                                                              |                     |                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Barbara Parey MD                                                                                                                                                                                                                                                                                          |  |                                                                                                                            |  | 22e. ADDRESS<br>9000 Franklin Square Dr, 21237                                                                                                             |  |                                                                                              |  |                                                                                                                         |                     |                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>6/7/79                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Pine Grove                                                                                                           |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Rossville - BALTO MD                              |  |                                                                                                                         |                     |                                             |  |
| 24 FUNERAL DIRECTOR NAME<br>EVANS FUNERAL Chapel                                                                                                                                                                                                                                                                                                   |  |                                                                                                                            |  | ADDRESS<br>8800 Hartford Rd                                                                                                                                |  |                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 11 1979                                                                            |                     | 25b. REGISTRAR'S SIGNATURE<br>Ruthy McCurdy |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |  |                                                                                                                                                            |  |                                                                                                                            |  |                                                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                           |  | 9                                                                                                                                |  | 13653                                                                                                                                                      |  | REG. NO.                                                                                                                   |  |                                                                                                                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ottilee L. Green                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 6 1979                                                                                                         |  | 2b. HOUR<br>4:30 AM                                                                                                        |  |                                                                                                                                     |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4 RACE<br>White                                                                                                                  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 8, 1925                                                                                                          |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS.                                                                                  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                                                                          |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Md.                                                                                                                                                                                                                                                                                                                                                                           |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                               |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                                                       |  |                                                                                                                                     |  |
| 10 CITY OR TOWN OF DEATH<br>Owings Mills                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>122 S. Ritters Lane |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Balto. Co. School Board                                                                 |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                                           |  |                                                                                                                                     |  |
| 13a STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 13b COUNTY<br>Balto.                                                                                                             |  | 13c CITY OR TOWN<br>Owings Mills                                                                                                                           |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                        |  | 13e STREET ADDRESS<br>122 S. Ritters Lane                                                                                           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alvan Leister                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nettie Brehm                                                                                              |  |                                                                                                                            |  |                                                                                                                                     |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                        |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-20-8517                                                            |  | 17 INFORMANT ADDRESS<br>Mr. Samuel S. Green Owings Mills, Md.                                                                                              |  |                                                                                                                            |  |                                                                                                                                     |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma - Colon -</u><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <u>Multiple metastasis</u><br>(c) <u>Due to, or as a consequence of</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u><br><u>1 year</u> |  |                                                                                                                                  |  |                                                                                                                                                            |  |                                                                                                                            |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                                                     |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                          |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |                                                                                                                                     |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                         |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |                                                                                                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 16, 1978</u> to <u>June 6, 1979</u> , that (I) (we) last saw the deceased alive on <u>June 4, 1979</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                       |  |                                                                                                                                  |  |                                                                                                                                                            |  |                                                                                                                            |  |                                                                                                                                     |  |
| 22b SIGNATURE<br><u>O. E. McWilliams M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  | 22c. DATE SIGNED<br>16-6-79                                                                                                                                |  | 22d. ADDRESS<br>11904 Reisterstown Rd Reisterstown Md. 21136                                                               |  |                                                                                                                                     |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br>June 8, 79                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadow Ridge Memorial                                                                                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Howard Co. Md.                                                               |  |                                                                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Eline Funeral Home                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  |  | ADDRESS<br>Reisterstown, Md. 21136                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 8 1979                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>Henry McCreedy                                                                                        |  |

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      |                                                                                                                                                                 |                                                                                               |                                                                                                 |                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ABRAHAM L. GREENFIELD                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                      |                                                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 10, 1979                                          |                                                                                                 | 2b. HOUR<br>7:45A.M                                                                                                        |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE<br>White                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 13, 1901                                                                                                           |                                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York                                                                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                  |                                                                                                 |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Pikesville                                                                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Pikesville Nursing Home |                                                                                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Beauty Supplies Wholesale |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                      | 13b. COUNTY                                                                                                                                                     | 13c. CITY OR TOWN<br>Baltimore                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>4001 Clarks Lane Apt. 406                                                                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel Greenfield                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Fannie Unknown                                                                                                 |                                                                                               | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                      |                                                                                                                            |
| 16b. SOCIAL SECURITY NO.<br>217-01-6729                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                      | 17. INFORMANT<br>Mrs. Anne Greenfield                                                                                                                           |                                                                                               | 406 Apt                                                                                         |                                                                                                                            |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Muscle Tissue</u><br>410- <u>Sen Atass less + caled</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>weak self + chn Bar sules</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Parkinson</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |                                                                                                                                      |                                                                                                                                                                 |                                                                                               |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>hr                                                                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                        |                                                                                                                                      |                                                                                                                                                                 |                                                                                               |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                |                                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                  |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                      |                                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                          |                                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                               |                                                                                                                                      |                                                                                                                                                                 |                                                                                               |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><u>J. S. Markovits</u>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                      | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                               | 22c. DATE SIGNED<br>6/14/79.                                                                    |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. S. MARKOVITS                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                      | 22e. ADDRESS<br>1102195. D... & ...                                                                                                                             |                                                                                               |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>REMOVAL & BURIAL                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 23b. DATE<br>JUNE 10, 1979                                                                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Golda                                               |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>LONG ISLAND, NEW YORK                                                        |
| 24. FUNERAL DIRECTOR<br>NAME<br>Sol Levinson & Bros. Inc.                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | ADDRESS<br>6010 Reisterstown Rd.                                                                                                                                |                                                                                               | 25a. DATE REC'D. BY REGISTRAR<br>JUN 13 1979                                                    | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia Melrody</u>                                                                      |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10001

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



*[Faint, illegible handwritten text, possibly a list or description of plant specimens.]*

*[Faint, illegible handwritten text at the bottom of the page, possibly a signature or date.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                            |  |                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                             |  | 7 9 13655                                                                                                                                |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |  |                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Rose C. Grogan</u>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                          |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>6-22-79</u>                                                                                                       |  | 2b. HOUR<br><u>4P</u> M                                                                                                    |  |                                                                            |  |
| 3. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><u>White</u>                                                                                                                  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>7 22 88</u>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>90</u> YRS                                                                           |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Md.</u>                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore Co.</u> MD.                                                           |  |                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><u>Towson</u>                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Stella Maris Hospice</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Secretary</u>                                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>B. &amp; O. R.R.</u>                                                               |  |                                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>Md.</u>                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br><u>Baltimore</u>                                                                                                          |  | 13c. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><u>Memorial Apts. 301 McEchen St. Baltimore Md.</u> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Thomas E. Grogan</u>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>SARAH C. BRANNON Bannan</u>                                                                             |  |                                                                                                                            |  |                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><u>A-368269-6354</u>                                                          |  | 17. INFORMANT<br>ADDRESS<br><u>Stella Maris Hospice 2500 Dulany Valley Rd. Towson Md. 21204</u>                                                             |  |                                                                                                                            |  |                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cd Colon</u><br><u>1539</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____           |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                      |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                            |  |                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                            |  |                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-19</u> , 19 <u>79</u> , to <u>6-22</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>6-22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                            |  |                                                                            |  |
| 22b. SIGNATURE<br><u>Eddie Nakkada M.D.</u>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>6-22-79</u>                                                                                         |  |                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Eddie Nakkada M.D.</u>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |  | 22e. ADDRESS<br><u>1205 York Rd. Lutherville Md. 21093</u>                                                                                                  |  |                                                                                                                            |  |                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><u>6-26-79</u>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>NEW CATHEDRAL</u>                                                                                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTA - Md.</u>                                                           |  |                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>J. Walter Gublin</u>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |  | ADDRESS<br><u>5444 BELAIR RD.</u>                                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 28 1979</u>                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McCreedy</u>                      |  |

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                |  |                                                                                  |  | 7 9 1 3 6 5 6<br>REG. NO.                                                                                                                            |  |                                                                                                                            |  |          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                     |  |                                                                                                                            |  | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Walter Groncki                                                                                                                                                                                                                                                                                                                                |  |                                                                                  |  | June 15, 1979                                                                                                                                        |  |                                                                                                                            |  | 1:50A.M. |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br>White                                                                 |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 26 1903                                                                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                                                                                 |  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Baltimore                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                              |  | 8. MARRIAGE STATUS<br>NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                               |  |          |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Franklin Sq. Hospital |  | 12a. USUAL OCCUPATION<br>Boiler House Operator                                                                                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Oil Refin.                                                                            |  |          |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  | 13b. COUNTY<br>Baltimore                                                                                                                             |  | 13c. CITY OR TOWN<br>Middle River                                                                                          |  |          |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Stanley Groncki                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Charolette Kosakowski                                                                                  |  |                                                                                                                            |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>0- 215 07 1401        |  | 17. INFORMANT ADDRESS<br>Marie Groncki, Wife Same                                                                                                    |  |                                                                                                                            |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>1913 Cardio Pulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Astrocytoma Left Parietal Lobe</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                  |  |                                                                                                                                                      |  |                                                                                                                            |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                 |  |                                                                                  |  |                                                                                                                                                      |  |                                                                                                                            |  |          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                            |  |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                            |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 17</u> , 19 <u>79</u> , to <u>June 15</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>June 15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                    |  |                                                                                  |  |                                                                                                                                                      |  |                                                                                                                            |  |          |
| 22b. SIGNATURE<br>Hyun                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>6:15:79                                                                                                |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Set Twar, M.D.                                                                                                                                                                                                                                                                                                                                             |  |                                                                                  |  | 22e. ADDRESS                                                                                                                                         |  |                                                                                                                            |  |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br>6/18/79                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus Cemetery                                                                                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore                                                                    |  |          |
| 24. FUNERAL DIRECTOR<br>Brudzinski Funeral Home PA 1407 Old Eastern Ave                                                                                                                                                                                                                                                                                                                             |  |                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 20 1979                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                  |  |          |



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UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

U. S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

DEPARTMENT OF AGRICULTURE

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WASHINGTON, D. C.

WASHINGTON, D. C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13657

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                          |                                                                                              |                                      |                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | 2a. DATE KNOWN OF DEATH                                                                                                                                  |                                                                                              | 2b. HOUR                             |                                                                     |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | 2c. DATE ESTI- MATED                                                                                                                                     |                                                                                              | 2d. HOUR                             |                                                                     |
| Betty Jean Guise                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | 6 12 1979                                                                                                                                                |                                                                                              | 10A                                  |                                                                     |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE                                                                                                 | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                                              | 7. IF UNDER 1 YR.                    | 7. IF UNDER 24 HRS.                                                 |
| Female                                                                                                                                                                                                                                                                                                                                                                                                                                 | White                                                                                                   | 7 9 40                                                                                                                                                   | 38 YRS.                                                                                      |                                      |                                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?                                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                                                     |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                    | U.S.A.                                                                                                  |                                                                                                                                                          |                                                                                              | Baltimore County MD.                 |                                                                     |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY    |                                                                     |
| Cockeysville                                                                                                                                                                                                                                                                                                                                                                                                                           | 10036 Hill Green Court                                                                                  | NONE                                                                                                                                                     |                                                                                              |                                      |                                                                     |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                             | 13b. COUNTY                                                                                             | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS                  |                                                                     |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                    | BALTO.                                                                                                  | ESSEX                                                                                                                                                    |                                                                                              | 10036 HILGREEN CIRCLE                |                                                                     |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      | 15. MOTHER'S MAIDEN NAME                                                                                | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                       |                                                                                              |                                      |                                                                     |
| EDWARD                                                                                                                                                                                                                                                                                                                                                                                                                                 | CLARA                                                                                                   | NO                                                                                                                                                       |                                                                                              |                                      |                                                                     |
| 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                               | 17. INFORMANT                                                                                           | ADDRESS                                                                                                                                                  |                                                                                              |                                      |                                                                     |
| 217-38-4265                                                                                                                                                                                                                                                                                                                                                                                                                            | STUART E. GUISE                                                                                         | ABOVE                                                                                                                                                    |                                                                                              |                                      |                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |                                                                                                                                                          |                                                                                              |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         |                                                                                                                                                          |                                                                                              |                                      |                                                                     |
| IMMEDIATE CAUSE (a) Acute pancreatitis complicating fatty liver                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                          |                                                                                              |                                      |                                                                     |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |                                                                                                                                                          |                                                                                              |                                      |                                                                     |
| (b)                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                                                                                                                          |                                                                                              |                                      |                                                                     |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |                                                                                                                                                          |                                                                                              |                                      |                                                                     |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                                                                                                                          |                                                                                              |                                      |                                                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                                                                                                                          |                                                                                              |                                      |                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |                                                                                              |                                      | 20. AUTOPSY?                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                          |                                                                                              |                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                                                                                              |                                      |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        | P.M. 19                                                                                                 |                                                                                                                                                          |                                                                                              |                                      |                                                                     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                              |                                      |                                                                     |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                                                                                         |                                                                                                                                                          |                                                                                              |                                      |                                                                     |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | TITLE (SPECIFY)                                                                                                                                          |                                                                                              | DATE SIGNED                          |                                                                     |
| Ann M. Dixon                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         | Assistant                                                                                                                                                |                                                                                              | 6/12/79                              |                                                                     |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | ADDRESS                                                                                                                                                  |                                                                                              |                                      |                                                                     |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | 111 Penn St. Balto., MD.                                                                                                                                 |                                                                                              |                                      |                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                              | 23b. DATE                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | 23d. LOCATION CITY OR TOWN                                                                   | COUNTY                               | STATE                                                               |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6/15/79                                                                                                 | ZION LUTHERAN                                                                                                                                            | ESSEX                                                                                        | BALTO.                               | MD.                                                                 |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            | 25b. REGISTRAR'S SIGNATURE                                                                   |                                      |                                                                     |
| CONNELLY F.H.                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         | JUN 19 1979                                                                                                                                              | [Signature]                                                                                  |                                      |                                                                     |



1 2 3 4 5 6 7

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
(VR A15 ME (5))  
15M/7/77

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                       |  |                    |  |                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                          |  | REG. NO. 13658                                                                   |  |                                                                                  |  |                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|-----------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>CLARENCE <del>DELL</del> GUMMEL                                                                                                                                                                                                                                                                                                                                                                         |  |                    |  |                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                          |  | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 6-2 1979 |  | 2b. HOUR 1:50 P.M.                                                               |  |                                               |  |
| 3. SEX Male                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE White      |  | 5. DATE OF BIRTH MONTH DAY YEAR 4/27/1895                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.                                                      |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                                                                                                                    |  | 7c. DATE PRONOUNCED DEAD 6-2-1979                                                |  | 2d. HOUR 4:15 P.M.                                                               |  |                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland                                                                                                                                                                                                                                                                                                                                                                                                            |  |                    |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                              |  |                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.                           |  |                                                                                  |  |                                               |  |
| 10. CITY OR TOWN OF DEATH Dundalk                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                    |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6833 Boston Avenue 21222 |  |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Gov't.                                                                                |  |                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY Electrician                                    |  |                                               |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                    |  |                    |  |                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                  |  |                                                                                  |  |                                               |  |
| 13a. STATE Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY Balto. |  | 13c. CITY OR TOWN Dundalk                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS 6833 Boston Ave. 21222                                                                                                               |  |                                                                                  |  |                                                                                  |  |                                               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Gummel                                                                                                                                                                                                                                                                                                                                                                                                             |  |                    |  |                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Unknown                                 |  |                                                                                                                                                          |  |                                                                                  |  |                                                                                  |  |                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No                                                                                                                                                                                                                                                                                                                                                                                         |  |                    |  | 16b. SOCIAL SECURITY NO. 218-22-0430                                                                                             |  |                                                                                              |  | 17. INFORMANT ADDRESS Temple Hills, Md. 20031 June G. Newlan 3704 Spring Terrace                                                                         |  |                                                                                  |  |                                                                                  |  |                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>410- DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>chronic cardio cerebral arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                    |  |                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                  |  |                                                                                  |  |                                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                           |  |                    |  |                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                  |  |                                                                                  |  |                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                           |  |                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                             |  |                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                                  |  |                                                                                  |  |                                               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                        |  |                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                      |  |                                                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                  |  |                                                                                  |  |                                               |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .       |  |                    |  |                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                  |  |                                                                                  |  |                                               |  |
| ACTUAL SIGNATURE <u>K.S. AHLUWALIA</u>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                    |  | TITLE (SPECIFY) M.D. <u>Deputy</u>                                                                                               |  |                                                                                              |  | MEDICAL EXAMINER                                                                                                                                         |  |                                                                                  |  | DATE SIGNED 6/2/79                                                               |  |                                               |  |
| EXAMINER'S NAME (TYPE OR PRINT) K.S. AHLUWALIA                                                                                                                                                                                                                                                                                                                                                                                                                |  |                    |  | ADDRESS 2112 Dundalk Av Balt 21222                                                                                               |  |                                                                                              |  |                                                                                                                                                          |  |                                                                                  |  |                                                                                  |  |                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation                                                                                                                                                                                                                                                                                                                                                                                                           |  |                    |  | 23b. DATE 6/4/1979                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY Green Mount                                               |  |                                                                                                                                                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.                            |  |                                                                                  |  |                                               |  |
| 24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc. Dundalk, Md                                                                                                                                                                                                                                                                                                                                                                                              |  |                    |  |                                                                                                                                  |  |                                                                                              |  |                                                                                                                                                          |  | 25a. DATE REC'D BY REGISTRAR JUN 4 1979                                          |  |                                                                                  |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> |  |

00000

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

12



1000-1000

1000-1000

BP

DHMM - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                            |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                       |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                            |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MARY MIDDLE LAST SUMNER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                            |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>6 19 79                                          |  | 2b. HOUR<br>1:49 PM                                                                                                                   |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>CAUC.                                                                                                           |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 8 78                                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.                                           |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CO. MD.                               |  |                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTO. CO. HOSP. |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                            |  |                                                                                                                                                             |  | 13b. COUNTY<br>Baltimore                                                             |  | 13c. CITY OR TOWN<br>Woodlawn                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Theodore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                            |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Julia Kelley                           |  |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>215-10-0126                                                                                    |  | 17. INFORMANT ADDRESS<br>Mrs. Doria Peregoy<br>6740 Brookmont Drive, Baltimore, MD 21207                                                                    |  |                                                                                      |  |                                                                                                                                       |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac standstill<br>4140 } DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart Disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) old myocardial infarction, chronic congestive heart failure |  |                                                                                                                            |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                       |  |
| 19a. DATE OF OPERATION<br>6/19/79                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>X                                                                      |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>X                                                                         |  |                                                                                      |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>X                                                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>Baltimore City MD                                                                                         |  |                                                                                      |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/19/79 to 6/19/79, that (I) (we) last saw the deceased alive on 6/19/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                                              |  |                                                                                                                            |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br>S. Tragoon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                            |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |                                                                                      |  | 22c. DATE SIGNED<br>6/19/79                                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. TRAGOON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                            |  | 22e. ADDRESS<br>Baltimore County General Hospital                                                                                                           |  |                                                                                      |  |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>6/22/79                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery                                                                                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore City MD                         |  |                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR NAME<br>Loring Byers Funeral Directors, P.A.<br>8728 Liberty Rd., Randallstown, MD 21133                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 20 1979                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>Hester, Hester                                         |  |                                                                                                                                       |  |

V C C O I V V

THE JOURNAL OF THE  
AMERICAN MEDICAL ASSOCIATION  
PUBLISHED WEEKLY  
CHICAGO, ILL., U.S.A.



TO HOSPITAL. ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon/papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
{VRA 15, 4} 7/78

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br><b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                              |                                                                                            | 9 1 3 6 6 0                                                                                                                                                                                                                                                              |                                                                                                                                  |                                                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--|
| FOR<br><b>STATE REGISTRAR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                              |                                                                                            | REG. NO.                                                                                                                                                                                                                                                                 |                                                                                                                                  |                                                                              |  |
| <b>1. DECEASED NAME</b><br><small>(TYPE OR PRINT)</small><br><div style="display: flex; justify-content: space-between;"><span>FIRST</span><span>MIDDLE</span><span>LAST</span></div> <div style="display: flex; justify-content: space-around; margin-top: 5px;">EDWARDJ.HAMELIN</div>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                               |  | <b>2a. DATE OF DEATH</b><br><div style="display: flex; justify-content: space-between;"><span>MONTH</span><span>DAY</span><span>YEAR</span></div> <div style="display: flex; justify-content: space-around; margin-top: 5px;">JUNE 6, 1979</div>                             |                                                                                            | <b>2b. HOUR</b><br><div style="display: flex; justify-content: space-between;"><span>HOURS</span><span>MIN.</span></div> <div style="display: flex; justify-content: space-around; margin-top: 5px;">5:30 a.m.</div>                                                     |                                                                                                                                  |                                                                              |  |
| <b>3 SEX</b><br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | <b>4 RACE</b><br>White                                                                                                                                                                                                                                                        |  | <b>5 DATE OF BIRTH</b><br><div style="display: flex; justify-content: space-between;"><span>MONTH</span><span>DAY</span><span>YEAR</span></div> <div style="display: flex; justify-content: space-around; margin-top: 5px;">Aug. 18, 1905</div>                              |                                                                                            | <b>6 AGE</b> (IN YEARS LAST BIRTHDAY)<br><div style="display: flex; justify-content: space-between;"><span>YEARS</span><span>MONTHS</span><span>DAYS</span></div> <div style="display: flex; justify-content: space-around; margin-top: 5px;">73</div>                   |                                                                                                                                  |                                                                              |  |
| <b>7a. BIRTHPLACE</b> (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | <b>7b. CITIZEN OF WHAT COUNTRY?</b><br>U.S.A.                                                                                                                                                                                                                                 |  | <b>8</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                           |                                                                                            | <b>9 BALTIMORE CITY OR COUNTY OF DEATH</b><br>BALTIMORE COUNTY MD.                                                                                                                                                                                                       |                                                                                                                                  |                                                                              |  |
| <b>10 CITY OR TOWN OF DEATH</b><br>TOWSON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | <b>11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION</b><br><small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small><br>SAINT JOSEPH HOSPITAL                                                                                                                      |  |                                                                                                                                                                                                                                                                              |                                                                                            | <b>12a. USUAL OCCUPATION</b><br><small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small><br>Mechanic                                                                                                                                                                       |                                                                                                                                  | <b>12b. KIND OF BUSINESS OR INDUSTRY</b><br>Automobile                       |  |
| <b>USUAL RESIDENCE</b> (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>13a STATE</b><br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | <b>13b COUNTY</b><br>Baltimore                                                                                                                                                                                                                                                |  | <b>13c CITY OR TOWN</b><br>21234                                                                                                                                                                                                                                             |                                                                                            | <b>13d. INSIDE CITY LIMITS?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                   |                                                                                                                                  | <b>13e STREET ADDRESS</b><br>1707 Edgewood Road                              |  |
| <b>14 FATHER'S NAME</b><br><div style="display: flex; justify-content: space-between;"><span>FIRST</span><span>MIDDLE</span><span>LAST</span></div> <div style="display: flex; justify-content: space-around; margin-top: 5px;">JohnN.Hamelin           </div>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                               |  | <b>15. MOTHER'S MAIDEN NAME</b><br><div style="display: flex; justify-content: space-between;"><span>FIRST</span><span>MIDDLE</span><span>LAST</span></div> <div style="display: flex; justify-content: space-around; margin-top: 5px;">WilhelinaLangmantel           </div> |                                                                                            |                                                                                                                                                                                                                                                                          |                                                                                                                                  |                                                                              |  |
| <b>16a WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br><small>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)</small><br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | <b>16b SOCIAL SECURITY NO.</b><br>213-05-7723                                                                                                                                                                                                                                 |  | <b>17 INFORMANT ADDRESS</b><br>Viola Hamelin 1707 Edgewood Rd. 21234                                                                                                                                                                                                         |                                                                                            |                                                                                                                                                                                                                                                                          |                                                                                                                                  |                                                                              |  |
| <b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br><b>PART I. DEATH WAS CAUSED BY:</b><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><b>IMMEDIATE CAUSE (a)</b> Carcinoma of Lung with metastasis</p> <p><b>DOE TO, OR AS A CONSEQUENCE OF</b></p> <p><b>(b)</b> Pathological Fracture (R) Femur</p> <p><b>DOE TO, OR AS A CONSEQUENCE OF</b></p> <p><b>(c)</b></p> </div> <div style="width: 35%; text-align: center;"> <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p> </div> </div> |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                              |                                                                                            |                                                                                                                                                                                                                                                                          |                                                                                                                                  |                                                                              |  |
| <b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                              |                                                                                            |                                                                                                                                                                                                                                                                          |                                                                                                                                  |                                                                              |  |
| <b>19a DATE OF OPERATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | <b>19b CONDITION FOR WHICH OPERATION WAS PERFORMED</b>                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                              | <b>20a AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                                                                                                                                                          | <b>20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                              |  |
| <b>21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | <b>21b TIME OF INJURY</b><br><div style="display: flex; justify-content: space-between;"><span>HOUR A.M.</span><span>MONTH</span><span>DAY</span><span>YEAR</span></div> <div style="display: flex; justify-content: space-around; margin-top: 5px;">P.M. 19           </div> |  | <b>21c HOW INJURY OCCURRED</b> (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                                                                                                                                         |                                                                                            |                                                                                                                                                                                                                                                                          |                                                                                                                                  |                                                                              |  |
| <b>21d INJURY OCCURRED</b><br><div style="display: flex; justify-content: space-between;"><span>WHILE AT WORK</span><span>NOT WHILE AT WORK</span></div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"><input type="checkbox"/></div>                                                                                                                                                                                                                                                                                                              |  | <b>21e PLACE OF INJURY</b><br><small>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</small>                                                                                                                                                                                   |  | <b>21f LOCATION</b><br><div style="display: flex; justify-content: space-between;"><span>STREET</span><span>CITY OR TOWN</span><span>COUNTY</span><span>STATE</span></div>                                                                                                   |                                                                                            |                                                                                                                                                                                                                                                                          |                                                                                                                                  |                                                                              |  |
| <b>22a I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 20, 1979, to June 6, 1979, that we lost saw the deceased alive on above, and that in our opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                              |                                                                                            |                                                                                                                                                                                                                                                                          |                                                                                                                                  |                                                                              |  |
| <b>22b SIGNATURE</b><br>Samuel M. Dona M.D.<br>DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                               |  | <b>22c DATE SIGNED</b><br>6/7/79<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                               |                                                                                            | <b>22d PHYSICIAN'S NAME</b> (TYPE OR PRINT)<br>SAMUEL M. DONA M.D.                                                                                                                                                                                                       |                                                                                                                                  | <b>22e ADDRESS</b><br>7620 York Road, Towson, MD 21204<br>St Joseph Hospital |  |
| <b>23a BURIAL, CREMATION, REMOVAL</b> (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | <b>23b DATE</b><br>June 9, '79                                                                                                                                                                                                                                                |  | <b>23c NAME OF CEMETERY OR CREMATORY</b><br>Baltimore Cemetery                                                                                                                                                                                                               |                                                                                            | <b>23d LOCATION</b><br><div style="display: flex; justify-content: space-between;"><span>CITY OR TOWN</span><span>COUNTY</span><span>STATE</span></div> <div style="display: flex; justify-content: space-around; margin-top: 5px;">Baltimore, Maryland           </div> |                                                                                                                                  |                                                                              |  |
| <b>24 FUNERAL DIRECTOR</b><br><div style="display: flex; justify-content: space-between;"><span>NAME</span><span>ADDRESS</span></div> <div style="display: flex; justify-content: space-around; margin-top: 5px;">William E. Johnson 8521 Loch Raven Blvd.           </div>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                               |  | <b>25a DATE REC'D. BY REGISTRAR</b><br>JUN 7 1979                                                                                                                                                                                                                            |                                                                                            | <b>25b REGISTRAR'S SIGNATURE</b><br>Fitzgerald                                                                                                                                                                                                                           |                                                                                                                                  |                                                                              |  |



*[Faint, illegible handwriting in the center of the page]*



*[Faint, illegible handwriting at the bottom of the page]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         |  |                                                                                                                                                            |                                                           |                                                                                                                                 |                                                                                                 |                                                                                                                            |                                         | REG. NO. 13661                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>ELMER J. HAMMEL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         |  |                                                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR<br>JUNE 23 79            |                                                                                                                                 |                                                                                                 | 2b. HOUR<br>4:20AM                                                                                                         |                                         |                                              |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4 RACE<br>White                                                                                                                         |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>Jan. 16, 1898                                                                                                            |                                                           | 6 AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.                                                                                       |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                                                                   |                                         |                                              |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A                                                                                                   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                           | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.                                                                            |                                                                                                 |                                                                                                                            |                                         |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALTO. MEDICAL CENTER |  |                                                                                                                                                            |                                                           | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Master Plumber                                                 |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                         |                                              |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |  |                                                                                                                                                            | 13b. CITY OR TOWN<br>Baltimore                            |                                                                                                                                 | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13d. STREET ADDRESS<br>5430 Belair Road |                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George Hammel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         |  |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br>Barbara Michling |                                                                                                                                 |                                                                                                 |                                                                                                                            |                                         |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO<br>WW 1                                                                                                         |  | 17. INFORMANT<br>Mrs. Thelma G. Hammel                                                                                                                     |                                                           | ADDRESS<br>same                                                                                                                 |                                                                                                 |                                                                                                                            |                                         |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>GASTRO-INTESTINAL BLEEDING</b> |  |                                                                                                                                         |  |                                                                                                                                                            |                                                           |                                                                                                                                 |                                                                                                 |                                                                                                                            |                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |  |                                                                                                                                                            |                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                         |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |                                                           |                                                                                                                                 |                                                                                                 |                                                                                                                            |                                         |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |                                                           |                                                                                                                                 |                                                                                                 |                                                                                                                            |                                         |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 13 79</b> , to <b>JUNE 23 79</b> , that (I) (we) lost saw the deceased alive on <b>JUNE 23 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.                                                                                                                                                                                                       |  |                                                                                                                                         |  |                                                                                                                                                            |                                                           |                                                                                                                                 |                                                                                                 |                                                                                                                            |                                         |                                              |  |
| 22b. SIGNATURE<br><i>S. P. Girdhar</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         |  | DEGREE                                                                                                                                                     |                                                           | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br>6/23/79                                                                                                |                                         |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. P. GIRDHAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         |  | 22e. ADDRESS<br>6701 NORTH CHARLES ST. 21204                                                                                                               |                                                           |                                                                                                                                 |                                                                                                 |                                                                                                                            |                                         |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>June 26, 1979                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood                                                                                                             |                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                                                     |                                                                                                 |                                                                                                                            |                                         |                                              |  |
| 24. FUNERAL DIRECTOR NAME<br>Leonard J. Ruck Inc. Baltimore, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 26 1979                                                                                                               |                                                           | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony J. Brady</i>                                                                           |                                                                                                 |                                                                                                                            |                                         |                                              |  |

10001

JUNE 22 1964

J. J. J.

FILE

81

10001

BILLING

GREATER BALTIC MEDICAL CENTER

10001

CLINICAL DEPT

GASTRO-INTESTINAL MEDICINE

JUNE 22 1964

J. J. J.

JUNE 22

ST. JOHN'S CHURCH

10001

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                       |  |                         |                                 |                                                                                                                                            |  |                                                                                                                      |  |                                                                                                                                                          |                                                                                                 | 13662                                                                               |                                                     |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------|--|
| FOR<br>1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                         |                                 |                                                                                                                                            |  |                                                                                                                      |  |                                                                                                                                                          |                                                                                                 | REG. NO.                                                                            |                                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JEFFREY ALAN HARRIS</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                         |                                 |                                                                                                                                            |  |                                                                                                                      |  |                                                                                                                                                          |                                                                                                 | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>June 23 1979</b> 3AM                        |                                                     |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>White</b> |                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Feb. 21, 1977</b>                                                                                    |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY) <b>2 YRS.</b>                                                                    |  | IF UNDER 1 YR. MONTHS DAYS                                                                                                                               |                                                                                                 | IF UNDER 24 HRS. HOURS MIN.                                                         |                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                         |                                 | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                 |  |                                                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                  |                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                         |                                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1304 Wine Spring Lane</b> |  |                                                                                                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>n/a</b>                                                                              |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |                                                     |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         | 13b. COUNTY<br><b>Baltimore</b> |                                                                                                                                            |  | 13c. CITY OR TOWN<br><b>Towson</b>                                                                                   |  |                                                                                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                     | 13e. STREET ADDRESS<br><b>1 Charles Ridge Garth</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alan E. Harris</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                         |                                 |                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Frances Schull</b>                                               |  |                                                                                                                                                          |                                                                                                 |                                                                                     |                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                            |  |                         |                                 | 16b. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                    |  | 17. INFORMANT<br><b>Mr. Alan E. Harris</b>                                                                           |  |                                                                                                                                                          |                                                                                                 | ADDRESS<br><b>Same as # 13</b>                                                      |                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9108 Drowning</b><br>IMMEDIATE CAUSE (a) <b>Drowning</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                        |  |                         |                                 |                                                                                                                                            |  |                                                                                                                      |  |                                                                                                                                                          |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>                       |                                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                           |  |                         |                                 |                                                                                                                                            |  |                                                                                                                      |  |                                                                                                                                                          |                                                                                                 |                                                                                     |                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                         |                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                          |  |                                                                                                                      |  |                                                                                                                                                          |                                                                                                 | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                     |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                |  |                         |                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3:00 June 1979</b>                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Apparently Wounded into Pool</b> |  |                                                                                                                                                          |                                                                                                 |                                                                                     |                                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                |  |                         |                                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home Pool</b>                                                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1304 Wine Spring Lane Baltimore</b>                          |  |                                                                                                                                                          |                                                                                                 |                                                                                     |                                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |                                 |                                                                                                                                            |  |                                                                                                                      |  |                                                                                                                                                          |                                                                                                 |                                                                                     |                                                     |  |
| ACTUAL SIGNATURE<br><b>Charles F. Donnell</b> M.D.                                                                                                                                                                                                                                                                                                                                                                                            |  |                         |                                 |                                                                                                                                            |  | TITLE (SPECIFY)<br><b>Deputy</b>                                                                                     |  |                                                                                                                                                          | DATE SIGNED<br><b>6/23/79</b>                                                                   |                                                                                     |                                                     |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                            |  |                         |                                 |                                                                                                                                            |  | ADDRESS                                                                                                              |  |                                                                                                                                                          |                                                                                                 |                                                                                     |                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |                                 | 23b. DATE<br><b>6/26/79</b>                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fairfax Memorial Park</b>                                                   |  |                                                                                                                                                          |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Fairfax Virginia</b>               |                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. 1050 York Road</b>                                                                                                                                                                                                                                                                                                                                                  |  |                         |                                 |                                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>                                                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barney McBrady</b>                                                                                                      |                                                                                                 |                                                                                     |                                                     |  |

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/77

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

XC 13 532 132

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                             |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       |                                                                                                                                 |                                            |                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------|-----------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                         |         | FIRST                                                                                                     | MIDDLE           | LAST                                                                                                                                                        | 2a. DATE OF DEATH                                        |                                                                     | MONTH                 | DAY                                                                                                                             | YEAR                                       | 2b. HOUR                                                       |  |
| SIDNEY                                                                                                                                                                                                                                                                                                                      |         |                                                                                                           |                  | HASKINS                                                                                                                                                     | JUNE 28, 1979                                            |                                                                     |                       |                                                                                                                                 |                                            | 10:00P <sup>M</sup>                                            |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                      | 4. RACE |                                                                                                           | 5. DATE OF BIRTH |                                                                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)                          |                                                                     | IF UNDER 1 YEAR       |                                                                                                                                 | IF UNDER 24 HRS                            |                                                                |  |
| MALE                                                                                                                                                                                                                                                                                                                        | BLACK   |                                                                                                           | MARCH 15, 1907   |                                                                                                                                                             | 72                                                       |                                                                     | MONTHS                |                                                                                                                                 | DAYS                                       |                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                   |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                       |                                                                                                                                 |                                            |                                                                |  |
| VIRGINIA                                                                                                                                                                                                                                                                                                                    |         | U.S.A.                                                                                                    |                  |                                                                                                                                                             |                                                          | BALTIMORE COUNTY                                                    |                       | MD.                                                                                                                             |                                            |                                                                |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                   |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                  |                                                                                                                                                             |                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |                       | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                               |                                            |                                                                |  |
| FORT HOWARD                                                                                                                                                                                                                                                                                                                 |         | V.A. MEDICAL CENTER                                                                                       |                  |                                                                                                                                                             |                                                          |                                                                     |                       |                                                                                                                                 |                                            |                                                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                     |         |                                                                                                           |                  |                                                                                                                                                             | 13a. INSIDE CITY LIMITS?                                 |                                                                     | 13b. STREET ADDRESS   |                                                                                                                                 |                                            |                                                                |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                  |         | 13b. COUNTY                                                                                               |                  | 13c. CITY OR TOWN                                                                                                                                           |                                                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       | 2523 POPE LANE                                                                                                                  |                                            |                                                                |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                    |         | BALTIMORE                                                                                                 |                  |                                                                                                                                                             |                                                          |                                                                     |                       |                                                                                                                                 |                                            |                                                                |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                           |         |                                                                                                           |                  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME                                 |                                                                     |                       |                                                                                                                                 |                                            |                                                                |  |
| FIRST                                                                                                                                                                                                                                                                                                                       |         | MIDDLE                                                                                                    |                  | LAST                                                                                                                                                        |                                                          | FIRST                                                               |                       | MIDDLE                                                                                                                          |                                            | LAST                                                           |  |
| Henderson                                                                                                                                                                                                                                                                                                                   |         |                                                                                                           |                  | Haskins                                                                                                                                                     |                                                          | Lucinda                                                             |                       |                                                                                                                                 |                                            |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                        |         |                                                                                                           |                  |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES) |                                                                     | 17. INFORMANT ADDRESS |                                                                                                                                 |                                            |                                                                |  |
| YES                                                                                                                                                                                                                                                                                                                         |         |                                                                                                           |                  |                                                                                                                                                             | WWII                                                     |                                                                     | 213 09 0423           |                                                                                                                                 |                                            |                                                                |  |
|                                                                                                                                                                                                                                                                                                                             |         |                                                                                                           |                  |                                                                                                                                                             | CLINICAL RECORDS, V.A.M.C. FORT HOWARD, MD               |                                                                     |                       |                                                                                                                                 |                                            |                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.                                                                                                                                                                                                                    |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       |                                                                                                                                 |                                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                |  |
| IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF LUNGS WITH                                                                                                                                                                                                                                                                   |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       |                                                                                                                                 |                                            | 2 Months                                                       |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF METASTASIS                                                                                                                                                                                                                                                                              |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       |                                                                                                                                 |                                            |                                                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                              |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       |                                                                                                                                 |                                            |                                                                |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                          |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       |                                                                                                                                 |                                            |                                                                |  |
| (c)                                                                                                                                                                                                                                                                                                                         |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       |                                                                                                                                 |                                            |                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                         |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       |                                                                                                                                 |                                            |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |         |                                                                                                           |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                          |                                                                     |                       | 20a. AUTOPSY?                                                                                                                   |                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                             |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |                                            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |         |                                                                                                           |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                          |                                                                     |                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                  |                                            |                                                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                |         |                                                                                                           |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                          |                                                                     |                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                               |                                            |                                                                |  |
|                                                                                                                                                                                                                                                                                                                             |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       |                                                                                                                                 |                                            |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 22, 19 79, to JUNE 28, 19 79, that (I) (we) last saw the deceased alive on JUNE 28, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       |                                                                                                                                 |                                            |                                                                |  |
| 22b. SIGNATURE<br>Vadhana C. Claud, M.D.                                                                                                                                                                                                                                                                                    |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       | DEGREE<br>MD.                                                                                                                   |                                            | 22c. DATE SIGNED<br>6/29/79                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VADHANA C. CLAUD, M.D.                                                                                                                                                                                                                                                             |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                            |                                                                |  |
| 22e. ADDRESS<br>V.A.M.C. FORT HOWARD, MD                                                                                                                                                                                                                                                                                    |         |                                                                                                           |                  |                                                                                                                                                             |                                                          |                                                                     |                       |                                                                                                                                 |                                            |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                   |         |                                                                                                           |                  | 23b. DATE                                                                                                                                                   |                                                          | 23c. NAME OF CEMETERY OR CREMATORY                                  |                       |                                                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |                                                                |  |
| BURIAL                                                                                                                                                                                                                                                                                                                      |         |                                                                                                           |                  | 7/3/79                                                                                                                                                      |                                                          | MEADOW RIDGE                                                        |                       |                                                                                                                                 | 7250 WASHINGTON BLVD, MD.                  |                                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                |         |                                                                                                           |                  |                                                                                                                                                             |                                                          | 25a. DATE REC'D. BY REGISTRAR                                       |                       |                                                                                                                                 | 25b. REGISTRAR'S SIGNATURE                 |                                                                |  |
| MARCH FUNERAL HOME 1101 EAST NORTH AVENUE                                                                                                                                                                                                                                                                                   |         |                                                                                                           |                  |                                                                                                                                                             |                                                          | JUL 2 1979                                                          |                       |                                                                                                                                 | [Signature]                                |                                                                |  |

00001

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

1917

1

DATE OF RECEIPT: MAY 15 1917

NAME OF DONOR: J. H. HARRIS

ADDRESS OF DONOR: 1234 MAIN ST. WASHINGTON, D. C.

NAME OF RECIPIENT: U. S. DEPT. OF AGRICULTURE

ADDRESS OF RECIPIENT: BUREAU OF PLANT INDUSTRY

QUANTITY: 100

REMARKS: 100

DATE OF DELIVERY: MAY 15 1917

NAME OF DELIVERER: J. H. HARRIS

ADDRESS OF DELIVERER: 1234 MAIN ST. WASHINGTON, D. C.

QUANTITY: 100

REMARKS: 100

DATE OF RECEIPT: MAY 15 1917

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ADDRESS OF RECIPIENT: BUREAU OF PLANT INDUSTRY

QUANTITY: 100

REMARKS: 100



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 3 6 6 4

1. FOR  
STATE  
REGISTRAR

|                                                                    |  |                                                                                                                                                    |                                                       |                                                                                                                                                             |                             |                                                                                                 |  |
|--------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RICHARD Ives HAVER, Sr.</b> |  |                                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-12-79</b> |                                                                                                                                                             | 2b. HOUR<br><b>10:14</b> AM |                                                                                                 |  |
| 3. SEX<br><b>Male</b>                                              |  | 4. RACE<br><b>White</b>                                                                                                                            |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 / 16 / 1931</b>                                                                                                 |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b> YRS.                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wisconsin</b>      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                      |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown,</b>                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County Gen. Hospital</b> |                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired- U.S. Navy</b>                                                               |                             | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |
| 13a. STATE<br><b>Maryland</b>                                      |  | 13b. COUNTY<br><b>Carroll</b>                                                                                                                      |                                                       | 13c. CITY OR TOWN<br><b>Sykesville</b>                                                                                                                      |                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Darrell Haver</b>     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Darel Ives</b>                                                                                 |                                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                          |                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW 2</b>                          |  |
| 17. INFORMANT<br><b>Mrs. Mary Haver</b>                            |  | 18. ADDRESS<br><b>1519 Woodridge Lane Sykesville, Md. 21784</b>                                                                                    |                                                       |                                                                                                                                                             |                             |                                                                                                 |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**1539**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-5-</b> 19 <b>79</b> , to <b>6-12-</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6-12-</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Soonchul Hong</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6-12-1979</b>                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SOONCHUL HONG</b>                                                                                                                                                                                                                                                                                                  |  |                                                                        |  | 22e. ADDRESS<br><b>Baltimore County General Hospital</b>                                                                                             |  |                                                                                                                            |  |

|                                                                                                                                      |  |                                 |  |                                                          |  |                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------|--|----------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                           |  | 23b. DATE<br><b>June 15, 79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkridge Howard MD</b> |  |
| 24. FUNERAL DIRECTOR <b>Loring Byers Funeral Directors, P.A.</b><br>NAME ADDRESS<br><b>8728 Liberty Road Randallstown, Md. 21133</b> |  |                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 14 1979</b>      |  | 25b. REGISTRAR'S SIGNATURE<br><b>Fritzy Habudy</b>                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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*Handwritten signature or initials.*

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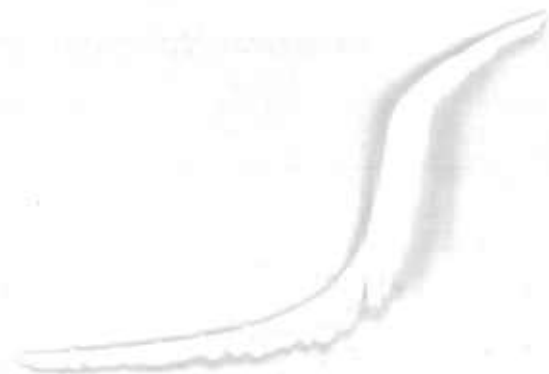
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                          |  |                                                                                                                                                            |                                                                                                |                                                                                     |                                     |                                                                                                                                       |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1- FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                           |  | REG. NO. 7 9 1 3 6 6 5                                                                                                   |  |                                                                                                                                                            |                                                                                                |                                                                                     |                                     |                                                                                                                                       |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Gretchen HEDRICK                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                          |  |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 27, 1979                                           |                                                                                     |                                     | 2b. HOUR<br>12:10PM                                                                                                                   |                                              |
| 3 SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4 RACE<br>W                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4/19/09                                                                                                              |                                                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)<br>70                                                |                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS.<br>HOURS MIN.                                                                      |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>GERMANY                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                      |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |                                     |                                                                                                                                       |                                              |
| 10 CITY OR TOWN OF DEATH<br>ROSSVILLE                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQ |  |                                                                                                                                                            |                                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HSWE            |                                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE MD 13b COUNTY BALTO 13c CITY OR TOWN MIDDLE RIVER                                                                                                                                                                                                                                                                                                 |  |                                                                                                                          |  |                                                                                                                                                            | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                     | 13e STREET ADDRESS<br>47 TORQUE WAY |                                                                                                                                       |                                              |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNK                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                          |  |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNK                                            |                                                                                     |                                     |                                                                                                                                       |                                              |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                              |  | 16b SOCIAL SECURITY NO.<br>213 22 627                                                                                    |  | 17 INFORMANT<br>MILDRED MANN                                                                                                                               |                                                                                                |                                                                                     | ADDRESS<br>ABOVE                    |                                                                                                                                       |                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Extensive acute myocardial infarction<br>410 - DUE TO, OR AS A CONSEQUENCE OF<br>(b) Atherosclerotic heart disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF<br>(c) Massive Pulmonary edema                                    |  |                                                                                                                          |  |                                                                                                                                                            |                                                                                                |                                                                                     |                                     |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                          |  |                                                                                                                                                            |                                                                                                |                                                                                     |                                     |                                                                                                                                       |                                              |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                          |  |                                                                                                                                                            |                                                                                                | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                |                                                                                     |                                     |                                                                                                                                       |                                              |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                               |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                    |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                |                                                                                     |                                     |                                                                                                                                       |                                              |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 26, 1979, to June 27, 1979, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 27, 1979, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |                                                                                                                          |  |                                                                                                                                                            |                                                                                                |                                                                                     |                                     |                                                                                                                                       |                                              |
| 22b SIGNATURE<br>Felipe Rubio                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                          |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |                                                                                                |                                                                                     |                                     | 22c DATE SIGNED<br>6/27/79                                                                                                            |                                              |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Felipe Rubio MD                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                          |  | 22e ADDRESS<br>9000 Franklin Square Dr. 21237                                                                                                              |                                                                                                |                                                                                     |                                     |                                                                                                                                       |                                              |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b DATE<br>6/30/79                                                                                                      |  | 23c NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH                                                                                                      |                                                                                                | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD                              |                                     |                                                                                                                                       |                                              |
| 24 FUNERAL DIRECTOR<br>NAME<br>J.G. CONNELLY                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                          |  | ADDRESS<br>300 MACE                                                                                                                                        |                                                                                                | 25a DATE REC'D. BY REGISTRAR<br>JUL 2 1979                                          |                                     | 25b REGISTRAR'S SIGNATURE<br>Ritzy McCurdy                                                                                            |                                              |

COCCI 21



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                       |                                                                                                                                                             |                                                                            |                                                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edna M. HEINS</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 7, 1979</b>             |                                                                                                                                                             |                                                       | 2b. HOUR<br><b>2:15 P.M.</b>                                                                                                                                |                                                                            |                                                                                                                               |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>White</b>                                                                                                                   |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 30, 1897</b>                                                                                                 |                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                                                                                           |                                                                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                                                         |                                                                            |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1353 Dartmouth Avenue</b> |                                                                        |                                                                                                                                                             |                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                                        |                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                          |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                           |                                                                        | 13c. CITY OR TOWN<br><b>Parkville</b>                                                                                                                       |                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |                                                                            | 13e. STREET ADDRESS<br><b>1353 Dartmouth Avenue</b>                                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry E. Rogers</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                           |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie Bond</b>                                                                                         |                                                       |                                                                                                                                                             |                                                                            |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                           |                                                                        | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>215-44-0898</b>                                                                                |                                                       | 17. INFORMANT<br>ADDRESS<br><b>Mrs. William M. Streett Same</b>                                                                                             |                                                                            |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Ante-natal carcinoma of left breast</b><br>1749<br>DUE TO OR AS A CONSEQUENCE OF <b>metastases to bones, brain</b><br>and (b) <b>Diabetes Mellitus (uncontrolled) 6 yrs</b><br>DUE TO OR AS A CONSEQUENCE OF <b>Hypertensive A.S.C.V.D. disease</b><br>(c) <b>12 yrs</b> |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                       |                                                                                                                                                             |                                                                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 yrs</b>                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Osteoporosis spine &amp; pelvis, Diverticulosis</b>                                                                                                                                                                                                               |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                       |                                                                                                                                                             |                                                                            |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                    |  |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                            |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                            |                                                                                                                               |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Feb 3, 1954</b> to <b>June 7, 1979</b> , that (I) (we) last saw the deceased alive on <b>June 6, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) saw the body after death.                                                                          |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                       |                                                                                                                                                             |                                                                            |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Harold V. Harbold M.D.</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                       | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                            | 22c. DATE SIGNED<br><b>June 8, 1979</b>                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Harold V. Harbold, M.D.</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                       | 22e. ADDRESS<br><b>4706 Harford Road Balto., Md.</b>                                                                                                        |                                                                            |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           | 23b. DATE<br><b>6-9-79</b>                                             |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b> |                                                                                                                                                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Md.</b> |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co.<br/>4905 York Road Balto., Md. 21212</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 8 1979</b>                                                                                                          |                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony K. Brady</b>                                                                         |  |

BP

00001





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |  | REG. NO. 9 13667                                                                                                                                            |  |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Mary Marian Helman</i>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>June 8 1979</i>                                                                                                      |  |                                                                                                                         |  |
| 3. SEX<br><i>F</i>                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><i>W</i>                                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>Sept. 15 1897</i>                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><i>82</i>                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>U.S.A PA.</i>                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>                                                                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore Co</i> MD.                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><i>Kingsville</i>                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>11940 Belair Road</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Homemaking</i>                                                                  |  |
| 13a. STATE<br><i>Md</i>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |  | 13b. COUNTY<br><i>Baltimore</i>                                                                                                                             |  | 13c. CITY OR TOWN<br><i>Kingsville</i>                                                                                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Francis Joseph McLaughlin</i>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Marjorie Quigley</i>                                                                                       |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br><i>165-22-1240</i>                                                                                     |  | 17. INFORMANT ADDRESS<br><i>JOHNNIE Chester 11940 Belair Road</i>                                                                                           |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cancer of Stomach</i><br><i>1579</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Myocardial Infarct, ASCVD Kidney Failure</i>                                                                                                                                                                           |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19.                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>June 7 1979</i> to <i>June 8 1979</i> , that (1) (we) last saw the deceased alive on <i>June 7 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                         |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><i>William A. Tyson MD.</i>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>           |  | 22c. DATE SIGNED<br><i>6-8-79</i>                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>William A. Tyson</i>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |  | 22e. ADDRESS<br><i>Box 158 Kingsville Md.</i>                                                                                                               |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><i>6/11/79</i>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Patrick's Catholic Cem.</i>                                                                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>TUNNEL HILL BALAIR PA.</i>                                                |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Lassahn Funeral Home</i>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |  | ADDRESS<br><i>7401 Belair Road</i>                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 12 1979</i>                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |  |                                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br><i>Larry McCuskey</i>                                                                     |  |

BP

70081



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 13668

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                |  |                                                                                                                              |                                                     |                                                                                                                                                            |  |                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARIE E HENNING                                                                                                         |  |                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 28 1979 |                                                                                                                                                            |  | 2b. HOUR<br>3 P M                                   |  |
| 3 SEX<br>Female                                                                                                                                                |  | 4 RACE<br>White                                                                                                              |                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN 16 1892                                                                                                          |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                       |                                                     | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO Co MD. |  |
| 10 CITY OR TOWN OF DEATH<br>Parkville                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8118 HARFORD RD |                                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>House Keep                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT Home        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Md BALTO Parkville |  |                                                                                                                              |                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                            |  | 13e. STREET ADDRESS<br>8118 HARFORD RD              |  |
| 14. FATHER'S NAME<br>14a. FIRST 14b. MIDDLE 14c. LAST<br>John HASZHECK                                                                                         |  |                                                                                                                              |                                                     | 15. MOTHER'S MAIDEN NAME<br>15a. FIRST 15b. MIDDLE 15c. LAST<br>MARY SMITH                                                                                 |  |                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-46-5410                                                       |                                                     | 17. INFORMANT<br>ADDRESS<br>MARIE FRIZZELL 3943 PERRY HALL RD                                                                                              |  |                                                     |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1: DEATH WAS CAUSED BY:

1749  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b) cancer of Breast, 1977

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

6 months

2 years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

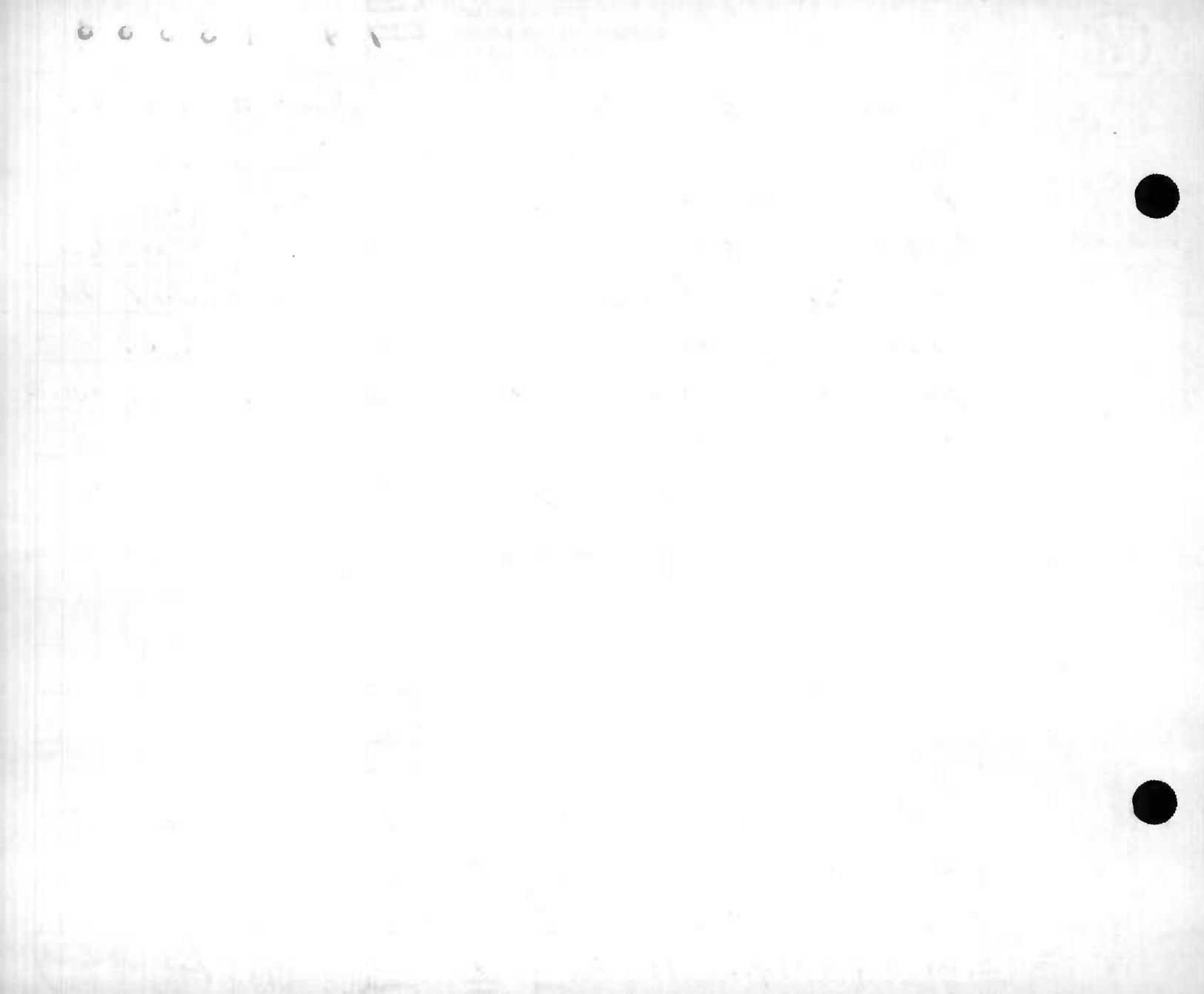
|                                                                                                                                                                                                                                                                                                                             |  |                                                                       |  |                                                                                                                                                      |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                       |  |                                                                                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Harold H Burns M.D. FACS                                                                                                                                                                                                                                                                                  |  |                                                                       |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>6-30-79                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harold H Burns M.D.                                                                                                                                                                                                                                                                |  |                                                                       |  | 22e. ADDRESS<br>8106 HARFORD RD                                                                                                                      |  |                                                                                                                            |  |

|                                                        |  |                     |  |                                                            |  |                                                                  |  |
|--------------------------------------------------------|--|---------------------|--|------------------------------------------------------------|--|------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL |  | 23b. DATE<br>7/2/79 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. JOHN LUM. Church |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville BALTO Md |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>EVANS Funeral Chapel   |  |                     |  | ADDRESS<br>8800 HARFORD RD                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                      |  |
|                                                        |  |                     |  |                                                            |  | 25b. REGISTRAR'S SIGNATURE<br>Loring McBrady                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                |  | 79 13669                                                                                               |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                      |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                                                                                       |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                        |  | 2b. HOUR                                     |  |
| JAMES                                                                                                                                                                                                                                                                                                 |  | E                                                                                                      |  | HENDERSON, Jr.                                                                                                                                           |  |                                                                                                                                            |  | 06 30 79                                                                                                                |  | 4:30 PM                                      |  |
| 3. SEX                                                                                                                                                                                                                                                                                                |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                            |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| M                                                                                                                                                                                                                                                                                                     |  | B                                                                                                      |  | 12 14 99                                                                                                                                                 |  | 79                                                                                                                                         |  |                                                                                                                         |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |  |                                                                                                                         |  |                                              |  |
| HENDERSON, NC                                                                                                                                                                                                                                                                                         |  | U.S.                                                                                                   |  |                                                                                                                                                          |  | Balto. Co. MD.                                                                                                                             |  |                                                                                                                         |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |  |                                                                                                                                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Baltimore                                                                                                                                                                                                                                                                                             |  | BCGH                                                                                                   |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                               |  | 13e. STREET ADDRESS                                                                                                     |  |                                              |  |
| MD                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | Balto.                                                                                                                                                   |  |                                                                                                                                            |  | 2741 Raynor                                                                                                             |  |                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                             |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| James                                                                                                                                                                                                                                                                                                 |  | HENDERSON                                                                                              |  | Nannie                                                                                                                                                   |  | HAWKINS                                                                                                                                    |  |                                                                                                                         |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                                                   |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                                                                                                    |  |                                                                                                                         |  |                                              |  |
| NO                                                                                                                                                                                                                                                                                                    |  | 218-03-5085                                                                                            |  | Elizabeth Folks                                                                                                                                          |  | 2700 W. Mosher St.                                                                                                                         |  |                                                                                                                         |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Seizure disorder.                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 4273 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Sp. Atrial fibrillation.                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
|                                                                                                                                                                                                                                                                                                       |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET                                                                                                                                     |  | CITY OR TOWN                                                                                                                               |  | COUNTY                                                                                                                  |  | STATE                                        |  |
|                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/30/79 to 6/30/79, that (I) (we) lost saw the deceased alive on 6/30/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                        |  | DEGREE                                                                                                 |  |                                                                                                                                                          |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                                                                                                        |  |                                              |  |
| N. J. Sureja                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  | 6/30/79                                                                                                                 |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                 |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| N. J. Sureja                                                                                                                                                                                                                                                                                          |  | BCGH                                                                                                   |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                             |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN                                                                                                                 |  | COUNTY                                                                                                                  |  | STATE                                        |  |
| Burial                                                                                                                                                                                                                                                                                                |  | 7/5/79                                                                                                 |  | Mt. Calvary Cem.                                                                                                                                         |  | Anne Arundel Co.,                                                                                                                          |  |                                                                                                                         |  | Md.                                          |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                             |  | ADDRESS                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                 |  |                                                                                                                         |  |                                              |  |
| Wm C March F/H                                                                                                                                                                                                                                                                                        |  | 1101 E. North Ave.                                                                                     |  | JUL 5 1979                                                                                                                                               |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |

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UNITED STATES  
DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF MEDICAL SERVICE



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W. C. Mendenhall  
JUL 5 1919  
JUL 5 1919  
JUL 5 1919

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                  |  |                                                                                                                                       |  | REG. NO. 79 13670                                                                                                                                           |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                            |  |                                                                                                                            |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>WALTER S. HENDERSON                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  | 2b. HOUR 9:54                                                                                                                                               |  |                                                                                                                            |  |
| 3. SEX M                                                                                                                                                                                                                                                                                                              |  | 4. RACE W                                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 21, 1885                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.                                                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales                                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Off. Supplies                                                                         |  |
| 13a. STATE Md.                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  | 13b. COUNTY Baltimore                                                                                                                                       |  | 13c. CITY OR TOWN Randallstown                                                                                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Daniel Henderson                                                                                                                                                                                                                                                               |  |                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Alice Ashcroft                                                                                                |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) no                                                                                                                                                                                                                                               |  |                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>212-07-6056                                                                                                                     |  | 17. INFORMANT ADDRESS<br>West Chester, Ohio; 45069<br>Martha H. Moorehead 8267 Copperneil Way                              |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PNEUMONIA<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>PROSTATIC OBSTRUCTION; URINARY TRACT INFECTION; SENILITY                                                                                                                       |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-1, 19 79, to 6-4, 19 79, that (I) (we) lost saw the deceased alive on 6-4, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.       |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE <i>Conanan</i> DEGREE                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>6-4-79                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ORLANDO B. CONANAN, M.D.                                                                                                                                                                                                                                                     |  |                                                                                                                                       |  | 22e. ADDRESS<br>BEGH-RANDALLSTOWN, Md. 21133                                                                                                                |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>6-8-79                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park                                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                                                |  |
| 24. FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Rd. Balto., Md. 21212                                                                                                                                                                                                                           |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 7 1979                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br><i>Pitney Kelcey</i>                                                                         |  |

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RECEIVED  
JUL 1 1979  
BALTIMORE



W. J. ...  
Baltimore County ...

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

FOR  
 1- STATE  
 REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                      |                                                                                                                                                             |                                                                               |                                                                                |                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SARAH GERTRUDE HENRY                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 5, 1979                           |                                                                                | 2b. HOUR<br>10:45 PM                                     |
| 3. SEX<br>female                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>caucasian                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 9, 1878                                                                                                          |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>100 YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |                                                          |
| 10. CITY OR TOWN OF DEATH<br>catonsville                                                                                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Shady Nook Nursing Home |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife | 12b. KIND OF BUSINESS OR INDUSTRY                                              |                                                          |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      |                                                                                                                                                             | 13b. CITY OR TOWN<br>Catonsville                                              | 13c. STREET ADDRESS<br>313 Wessling Circle                                     |                                                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George H. Tarbutton                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                      |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Simpson                 |                                                                                |                                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>214-74-6252                                                                                                                     |                                                                               | 17. INFORMANT<br>ADDRESS<br>Elizabeth M. Brunner see item 13                   |                                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Cardiac Vascular Failure</u><br>4370<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral Vascular Damage</u><br>5 months<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerosis</u><br>10 years<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last |                                                                                                                                      |                                                                                                                                                             |                                                                               |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                        |                                                                                                                                      |                                                                                                                                                             |                                                                               |                                                                                |                                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                                          |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      |                                                                                                                                                             |                                                                               |                                                                                |                                                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                   |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>AUG 10</u> , 19 <u>65</u> , to <u>JUNE 5</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>JUNE 5</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                   |                                                                                                                                      |                                                                                                                                                             |                                                                               |                                                                                |                                                          |
| 22b. SIGNATURE<br><u>Paul R. Ziegler</u>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                      | DEGREE<br>M.D.                                                                                                                                              |                                                                               | 22c. DATE SIGNED<br>JUNE 5, 1979                                               |                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL R. ZIEGLER                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                      | 22e. ADDRESS<br>M.D. 2902 CHESTNUT HILL ON E. City, MD                                                                                                      |                                                                               |                                                                                |                                                          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      | 23b. DATE<br>6-8-1979                                                                                                                                       |                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Spring Hill                              |                                                          |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Easton, Talbot, Md.                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                      |                                                                                                                                                             |                                                                               |                                                                                |                                                          |
| 24. FUNERAL DIRECTOR<br>NAME<br>Newman Funeral Home                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                      | ADDRESS<br>Easton, Md.                                                                                                                                      |                                                                               | 25a. DATE REC'D. BY REGISTRAR<br>JUN 11 1979                                   |                                                          |
| 25b. REGISTRAR'S SIGNATURE<br><u>Barry McCreedy</u>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                      |                                                                                                                                                             |                                                                               |                                                                                |                                                          |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



170514



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1- FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                               |  | 7 9 1 3 6 7 2<br>REG. NO.                                                                              |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                         |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                  |  | LAST                                                                                                                                       |  | 2a DATE OF DEATH MONTH DAY YEAR                                                                                        |  | 2b HOUR a                                    |  |
| Beulah Elizabeth                                                                                                                                                                                                                                                                                           |  | HERION                                                                                                 |  |                                                                                                                                                         |  |                                                                                                                                            |  | 6 26 79                                                                                                                |  | 10:00 M                                      |  |
| 3 SEX                                                                                                                                                                                                                                                                                                      |  | 4 RACE                                                                                                 |  | 5 DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                                                             |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                            |  | IF UNDER 74 HRS HOURS MIN                    |  |
| Female                                                                                                                                                                                                                                                                                                     |  | White                                                                                                  |  | July 4, 1906                                                                                                                                            |  | 72 YRS                                                                                                                                     |  |                                                                                                                        |  |                                              |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                   |  | 7b CITIZEN OF WHAT COUNTRY?                                                                            |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                                                        |  |                                                                                                                        |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                   |  | USA                                                                                                    |  |                                                                                                                                                         |  | Baltimore County MD.                                                                                                                       |  |                                                                                                                        |  |                                              |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                                                           |  |                                                                                                                        |  |                                              |  |
| Rossville 21237                                                                                                                                                                                                                                                                                            |  | Franklin Square Hospital                                                                               |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| 13a STATE                                                                                                                                                                                                                                                                                                  |  | 13b COUNTY                                                                                             |  | 13c CITY OR TOWN                                                                                                                                        |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                |  | 13e STREET ADDRESS                                                                                                     |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | Baltimore                                                                                                                                               |  |                                                                                                                                            |  | 2000 Odell Ave. 21237                                                                                                  |  |                                              |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                         |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                              |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| George - Eiseman                                                                                                                                                                                                                                                                                           |  | Katherine -                                                                                            |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                           |  | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                                                    |  | 17 INFORMANT ADDRESS                                                                                                                                    |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| No                                                                                                                                                                                                                                                                                                         |  | 218 22 4331                                                                                            |  | Audrey Lipka, daughter Balto., Md. 21213                                                                                                                |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory arrest                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| 1919 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Glioblastoma Multiform (Grade IV)                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                      |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                        |  |                                                                                                                                                         |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                          |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                    |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                      |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from 5/31/1979 to 6/26/1979, that (I) (we) lost saw the deceased alive on 6/26/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| 22b SIGNATURE                                                                                                                                                                                                                                                                                              |  | DEGREE                                                                                                 |  |                                                                                                                                                         |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED                                                                                                        |  |                                              |  |
| Ernesto Mendoza                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                                            |  | 6/26/79                                                                                                                |  |                                              |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                       |  | 22e ADDRESS                                                                                            |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| ERNESTO MENDOZA                                                                                                                                                                                                                                                                                            |  | 9000 Franklin Square Drive                                                                             |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                   |  | 23b DATE                                                                                               |  | 23c NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d LOCATION CITY OR TOWN COUNTY STATE                                                                                                     |  |                                                                                                                        |  |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                     |  | 6-29-79                                                                                                |  | Moreland Memorial Cem.                                                                                                                                  |  | Baltimore County, Maryland                                                                                                                 |  |                                                                                                                        |  |                                              |  |
| 24 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                        |  | 25a DATE REC'D. BY REGISTRAR                                                                           |  | 25b REGISTRAR'S SIGNATURE                                                                                                                               |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |
| Kruzdinski                                                                                                                                                                                                                                                                                                 |  | JUN 29 1979                                                                                            |  | Hickory McCreedy                                                                                                                                        |  |                                                                                                                                            |  |                                                                                                                        |  |                                              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                             |                                                                     |                                                                                                                                                             |                                                                                              |                                                                                   |                                                           |                                                                                                                         |                                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                             |                                                                     |                                                                                                                                                             | REG. NO. 9 13673                                                                             |                                                                                   |                                                           |                                                                                                                         |                                                                              |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Dale Edward Herman                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                             |                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 14, 1979                                            |                                                                                   |                                                           | 2b. HOUR<br>3:27 P.M.                                                                                                   |                                                                              |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br>W                                                                                                                |                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 1 24                                                                                                                   |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.                                        |                                                           | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |                                                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         |                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                      |                                                           |                                                                                                                         |                                                                              |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQ. HOSP |                                                                     |                                                                                                                                                             |                                                                                              | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BETH-STEEL       |                                                           | 12b. KIND OF BUSINESS OR INDUSTRY<br>STEEL                                                                              |                                                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN ESSEX                                                                                                                                                                                                                                                                                         |  |                                                                                                                             |                                                                     |                                                                                                                                                             | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                   | 13e. STREET ADDRESS<br>407 DELAWARE AVE                   |                                                                                                                         |                                                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>EDGAR D. HERMAN                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                             |                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>NELLIE FERRINO                                 |                                                                                   |                                                           |                                                                                                                         |                                                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                             |                                                                     |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>NW 2 217-18-1962                                                 |                                                                                   | 17. INFORMANT ADDRESS<br>ROSA HERMAN SAME AS ABOVE        |                                                                                                                         |                                                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive myocardial infarction</u><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive arteriosclerotic cardiovascular dis.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>cardiovascular dis.</u> |  |                                                                                                                             |                                                                     |                                                                                                                                                             |                                                                                              |                                                                                   |                                                           |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Same day<br>More than 10 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                        |  |                                                                                                                             |                                                                     |                                                                                                                                                             |                                                                                              |                                                                                   |                                                           |                                                                                                                         |                                                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                             |                                                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                         |  |                                                                                                                             | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |                                                           |                                                                                                                         |                                                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                              | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |                                                           |                                                                                                                         |                                                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>1972</u> , to <u>6/14</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/5</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                                                                            |  |                                                                                                                             |                                                                     |                                                                                                                                                             |                                                                                              |                                                                                   |                                                           |                                                                                                                         |                                                                              |
| 22b. SIGNATURE <u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                             |                                                                     |                                                                                                                                                             | DEGREE                                                                                       |                                                                                   |                                                           | 22c. DATE SIGNED<br>6/16/79                                                                                             |                                                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. BLATT, M.D.                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                             |                                                                     |                                                                                                                                                             | 22e. ADDRESS<br>406 EASTERN BLVD. BALTO. 21221 MD.                                           |                                                                                   |                                                           |                                                                                                                         |                                                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                             | 23b. DATE<br>6/18/79                                                |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill                                             |                                                                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>ESSEX BALTO MD |                                                                                                                         |                                                                              |
| 24. FUNERAL DIRECTOR NAME<br>CONNELLY, E.H.                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                             |                                                                     |                                                                                                                                                             | ADDRESS<br>300 MACE AVE                                                                      |                                                                                   | 25a. DATE REC'D BY REGISTRAR<br>JUN 21 1979               |                                                                                                                         | 25b. RECEIVED BY<br>[Signature]                                              |

01001 21



*[Faint, illegible handwriting on lined paper]*

1001 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                 |  |                                                                                                                                                                |                                                                    |                                                                                   |                                          |                                                                                                                         |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                 |  |                                                                                                                                                                |                                                                    |                                                                                   |                                          |                                                                                                                         |                                              |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>BESSIE E. Hessie</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                 |  |                                                                                                                                                                | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6 9 79</b>                  |                                                                                   | 2b. HOUR<br><b>9:05 AM</b>               |                                                                                                                         |                                              |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>White</b>                                                                                                         |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 21 1899</b>                                                                                                            |                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                                 |                                          | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                           |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.               |                                          |                                                                                                                         |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Middle River</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2 Decatur Road</b> |  |                                                                                                                                                                |                                                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaking</b>                                                                  |                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                 |  |                                                                                                                                                                | 13c. COUNTY<br><b>Baltimore</b>                                    |                                                                                   | 13d. CITY OR TOWN<br><b>Middle River</b> |                                                                                                                         | 13e. STREET ADDRESS<br><b>2 Decatur Road</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Benjamin Smith</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                 |  |                                                                                                                                                                | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Hattie Titlow</b> |                                                                                   |                                          |                                                                                                                         |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br><b>213-74-7483</b>                                                                                  |  | 17. INFORMANT<br><b>Howard Hessie</b>                                                                                                                          |                                                                    |                                                                                   | ADDRESS<br><b>1125 Rosedale Avenue</b>   |                                                                                                                         |                                              |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MULTIPLE STROKES</b><br><b>436-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |                                                                                                                                 |  |                                                                                                                                                                |                                                                    |                                                                                   |                                          |                                                                                                                         |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  |                                                                                                                                                                |                                                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>5/27 19 79</b>                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                 |                                                                    |                                                                                   |                                          |                                                                                                                         |                                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                 |                                                                    |                                                                                   |                                          |                                                                                                                         |                                              |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>5/27</b> 19 <b>79</b> , to <b>6/6</b> 19 <b>79</b> , that (1) (we) lost the deceased alive on <b>6/6</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)                                                                                                                                                  |  |                                                                                                                                 |  |                                                                                                                                                                |                                                                    |                                                                                   |                                          |                                                                                                                         |                                              |  |
| 22b. SIGNATURE <b>P. B. Lyon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> <b>House STAFF</b> |                                                                    |                                                                                   |                                          | 22c. DATE SIGNED<br><b>6/9/79</b>                                                                                       |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P. B. Lyon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                 |  | 22e. ADDRESS<br><b>Baltimore City Hospitals</b>                                                                                                                |                                                                    |                                                                                   |                                          |                                                                                                                         |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br><b>6/12/79</b>                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hills Cem.</b>                                                                                                  |                                                                    | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Middle River Baltimore Md.</b>      |                                          |                                                                                                                         |                                              |  |
| 24. FUNERAL DIRECTOR NAME<br><b>LASSAHN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                 |  | 7401 BELAIR RD 21236 ADDRESS                                                                                                                                   |                                                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 13 1979</b>                               |                                          | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCready</b>                                                                     |                                              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                 |  |                                                                                                                                           |  |                                                                                                                                                             |                                                                           |                                                                                      |                                      |                                                                                                                            |                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |  |                                                                                                                                                             |                                                                           |                                                                                      |                                      |                                                                                                                            |                                                                                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Evelyn E Hill</i>                                                                                                                                                                                                                                                        |  |                                                                                                                                           |  |                                                                                                                                                             | 2. DATE OF DEATH MONTH DAY YEAR HOUR<br><i>06 30 79 11<sup>45</sup> M</i> |                                                                                      |                                      |                                                                                                                            |                                                                                                 |  |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><i>white</i>                                                                                                                   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>11 12 06</i>                                                                                                          |                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>72</i> YRS.                                    |                                      | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.                                                              |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                             |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                  |                                      |                                                                                                                            |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><i>Randallstown</i>                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore County General</i> |  |                                                                                                                                                             |                                                                           | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>    |                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Own home</i>                                                                       |                                                                                                 |  |
| 13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                           |  |                                                                                                                                                             | 13b. COUNTY<br><i>Baltimore</i>                                           |                                                                                      | 13c. CITY OR TOWN<br><i>Woodlawn</i> |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Charles A. Loose</i>                                                                                                                                                                                                                                                                       |  |                                                                                                                                           |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Kate P. Chambees</i>     |                                                                                      |                                      |                                                                                                                            |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>no</i>                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><i>220-12-7899</i>                                                                                            |  | 17. INFORMANT ADDRESS<br><i>Mr. Harold J. Hill 7600 Clays Lane</i>                                                                                          |                                                                           |                                                                                      |                                      |                                                                                                                            |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Intestinal obstruction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>CVA - Aphasia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Diabetes</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                           |  |                                                                                                                                                             |                                                                           |                                                                                      |                                      |                                                                                                                            |                                                                                                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                   |  |                                                                                                                                           |  |                                                                                                                                                             |                                                                           |                                                                                      |                                      |                                                                                                                            |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |  |                                                                                                                                                             |                                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                           |                                                                                      |                                      |                                                                                                                            |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                           |                                                                                      |                                      |                                                                                                                            |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>06/08/79</i> to <i>6/30/79</i> , that (I) (we) last saw the deceased alive on <i>6/30/79</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.          |  |                                                                                                                                           |  |                                                                                                                                                             |                                                                           |                                                                                      |                                      |                                                                                                                            |                                                                                                 |  |
| 22b. SIGNATURE<br><i>J. J. Suep</i>                                                                                                                                                                                                                                                                                                  |  | DEGREE<br><i>M.D.</i>                                                                                                                     |  |                                                                                                                                                             |                                                                           | 22c. DATE SIGNED<br><i>6/30/79</i>                                                   |                                      |                                                                                                                            |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>J. J. Suep</i>                                                                                                                                                                                                                                                                           |  | 22e. ADDRESS<br><i>Baltimore County General Hospital</i>                                                                                  |  |                                                                                                                                                             |                                                                           |                                                                                      |                                      |                                                                                                                            |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>burial</i>                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><i>6/30/79</i>                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn Cemetery</i>                                                                                              |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Woodlawn Balto. Md.</i>             |                                      |                                                                                                                            |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Ambrose Funeral Home</i>                                                                                                                                                                                                                                                                          |  |                                                                                                                                           |  | 24b. ADDRESS<br><i>1328 Sulphur Spring Rd.</i>                                                                                                              |                                                                           | 25a. DATE REG'D. BY REGISTRAR<br><i>JUL 2 1979</i>                                   |                                      | 25b. REGISTRAR'S SIGNATURE<br><i>F. J. Kennedy</i>                                                                         |                                                                                                 |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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|                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                    |                                                                                                                                                            |                                                                                |                                                                                      |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LOUIS R. HILL                                                                                                                                                                                                                                                                                                                     |                                                                                                                                    |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 11 79<br>12 04 PM                     |                                                                                      |                                                                                                                            |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                            | 4 RACE<br>White                                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 25 1922                                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS                                      |                                                                                      | 7b. HOUR                                                                                                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Georgia                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                             | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                    |                                                                                      |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SAINT JOSEPH HOSPITAL |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Production | 12b. KIND OF BUSINESS OR INDUSTRY<br>Auto                                            |                                                                                                                            |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                    |                                                                                                                                                            | 13b. COUNTY<br>Baltimore                                                       | 13c. CITY OR TOWN<br>Baltimore                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>James E. Hill                                                                                                                                                                                                                                                                                                                   |                                                                                                                                    |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillian B. Harvey              |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                               |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br>400-28-8310                                                                                                                    | 17 INFORMANT Wife:<br>Josephine T. Hill 8333 Hillendale Road                   |                                                                                      |                                                                                                                            |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Inferior Myocardial Infarction<br>410-<br>DUETO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUETO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                    |                                                                                                                                                            |                                                                                |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 days                                                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                       |                                                                                                                                    |                                                                                                                                                            |                                                                                |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                 |                                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from June 9, 1979, to June 11, 1979, that (I) (we) lost saw the deceased alive on June 11, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                  |                                                                                                                                    |                                                                                                                                                            |                                                                                |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br>Charles B. Hatton M.D.                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                    | DEGREE<br>M.D.                                                                                                                                             |                                                                                | 22c. DATE SIGNED<br>6/11/79                                                          |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARLES B. HATTON                                                                                                                                                                                                                                                                                                               |                                                                                                                                    | 22e. ADDRESS<br>7600 OSKER DR. TOWSON, MD.                                                                                                                 |                                                                                |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                   | 23b. DATE<br>June 14 1979                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley                                                                                                       |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockleystville Maryland                |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Maryland                                                                                                                                                                                                                                                                                                |                                                                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br>JUN 13 1979                                                                                                               |                                                                                | 25b. REGISTRAR'S SIGNATURE<br>Fitzroy McCreedy                                       |                                                                                                                            |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                                                 |                                                                                      |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                      |  | 9 1 3 6 7 7<br>REG. NO.                                                                                                               |  |                                                                                                                                                             |                                                                                                 |                                                                                      |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Helen A Hines</i>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                       |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>6 17 79</i>                                              |                                                                                      |  | 2b. HOUR<br><i>10:30 AM</i>                                                                                                |  |
| 3. SEX<br><i>female</i>                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><i>White</i>                                                                                                               |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>12 01 88</i>                                                                                                          |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>90</i> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Md.</i>                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                  |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><i>Ruxton, Md.</i>                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Manor Care Ruxton</i> |  |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>homemaker</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |  |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                      |  |                                                                                                                            |  |
| 13a. STATE<br><i>Md.</i>                                                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br><i>Balto</i>                                                                                                           |  | 13c. CITY OR TOWN<br><i>Towson</i>                                                                                                                          |                                                                                                 | 13e. STREET ADDRESS<br><i>1300 Charmuth Rd.</i>                                      |  |                                                                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Dominic Larkin</i>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Margaret Boyle</i>                             |                                                                                      |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>                                                                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>W.A. 420779</i>                                                         |  | 17. INFORMANT ADDRESS<br><i>M. Eileen O'Connell Same</i>                                                                                                    |                                                                                                 |                                                                                      |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiac failure</i><br><i>4292</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Arterio Sclerotic Cardio Vascular Disease</i> years<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                                                 |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                               |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                                                 |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  |                                                                                                                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                 |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                 |                                                                                      |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 7</i> 19 <i>73</i> , to <i>June 17</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>June 16</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                              |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                                                 |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>Larkin, Hines</i>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  | DEGREE                                                                                                                                                      |                                                                                                 | 22c. DATE SIGNED<br><i>6/17/79</i>                                                   |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  | 22e. ADDRESS<br><i>3018 Hawks Mill Rd., Monkton 21111</i>                                                                                                   |                                                                                                 |                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br><i>6/20/1979</i>                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lorraine Cemetery</i>                                                                                              |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Woodlawn Balto Md</i>               |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Mitchell-Wiedefeld Home 6500 York Rd.</i>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 21 1979</i>                                                                                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Brady</i>                                 |  |                                                                                                                            |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove co-bonopapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                           |                                                                                                                                                                                          |                                                                                      |                                                                                      |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LENA B. HOFFMAN                                                                                                                                                                                                                                                                     |                                                                                                                                           |                                                                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR<br>JUNE 4, 1979                                     |                                                                                      | 2b. HOUR<br>12:45 M                                                                                                        |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                             | 4. RACE<br>WHITE                                                                                                                          | 5. DATE OF BIRTH MONTH DAY YEAR<br>OCT. 20, 1879                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>99                                                | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS                          |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>LITHUANIA                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                         |                                                                                      |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>PIKESVILLE                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN HEALTH FACILITY, GIVE STREET ADDRESS)<br>MILFORD MANOR NURSING HOME |                                                                                                                                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK AND MAIN SOURCE OF EARNING LIFE)<br>HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME                                         |                                                                                                                            |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                       |                                                                                                                                           |                                                                                                                                                                                          | 13b. COUNTY<br>BALTO.                                                                | 13c. CITY OR TOWN<br>BALTO.                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>AARON BAER MILLER                                                                                                                                                                                                                                                                                     |                                                                                                                                           |                                                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SARAH ETTA UNKNOWN                     |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                   |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br>213-52-4544J                                                                                                                                                 | 17. INFORMANT SYLVAN HOFFMAN ADDRESS<br>9221 OLD CT. RD. BALTO., MD 21207            |                                                                                      |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASCVD<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                                           |                                                                                                                                                                                          |                                                                                      |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Diabetes Mellitus                                                                                                                                                                                     |                                                                                                                                           |                                                                                                                                                                                          |                                                                                      |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                       |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                         |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                     |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                               |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                    |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                   |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/23/75, 19 to 6/4/79, 19, that (I) (we) last saw the deceased alive on 6/4/79, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                |                                                                                                                                           |                                                                                                                                                                                          |                                                                                      |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br>Dr Barry Gold                                                                                                                                                                                                                                                                                                              |                                                                                                                                           | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                                                                                      | 22c. DATE SIGNED<br>6/4/79                                                           |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. BARRY GOLD                                                                                                                                                                                                                                                                                      |                                                                                                                                           | 22e. ADDRESS<br>6804 PARK HTS. AVE. #21215                                                                                                                                               |                                                                                      |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                          | 23b. DATE<br>JUNE 5, 1979                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW YOUNG MEN                                                                                                                                   |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                     |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD., BALTO., MD 21215                                                                                                                                                                                                                                           |                                                                                                                                           |                                                                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR<br>JUN 6 1979                                          | 25b. REGISTRAR'S SIGNATURE<br>P. H. H. H.                                            |                                                                                                                            |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                           |  |                                                                                                                          |                                                                    |                                                                                                                                                            |                                                                                                 |                                                                                            |                                                 |                                                                                                                            |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                          | REG. NO.                                                           |                                                                                                                                                            |                                                                                                 |                                                                                            |                                                 |                                                                                                                            |                                              |
| 1 DECEASED NAME (TYPE OR PRINT)<br><b>BILLY RAY HOLLAND</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                          | 2a DATE OF DEATH<br><b>6- 22- 79</b>                               |                                                                                                                                                            |                                                                                                 | 2b HOUR<br><b>4:30PM</b>                                                                   |                                                 |                                                                                                                            |                                              |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                          |  | 4 RACE<br><b>White</b>                                                                                                   |                                                                    | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 24, 1926</b>                                                                                                  |                                                                                                 | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.                                           |                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mississippi</b>                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                              |                                                                    | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CO</b> MD.                             |                                                 |                                                                                                                            |                                              |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NO HOSPITAL FACILITY, GIVE STREET ADDRESS)<br><b>GBMC</b> |                                                                    |                                                                                                                                                            |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Equip. Operator</b> |                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                            |  |                                                                                                                          | 13b. COUNTY<br><b>Baltimore</b>                                    |                                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                            | 13e. STREET ADDRESS<br><b>1338 Cambria St.,</b> |                                                                                                                            |                                              |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hugh Holland</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Willie Ray</b> |                                                                                                                                                            |                                                                                                 |                                                                                            |                                                 |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br><b>W.W.II 409 34 8018</b>                                                                    |                                                                    | 17 INFORMANT ADDRESS<br><b>Betty Sue Holland, 1338 Cambria St.</b>                                                                                         |                                                                                                 |                                                                                            |                                                 |                                                                                                                            |                                              |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA LUNG</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                          |                                                                    |                                                                                                                                                            |                                                                                                 |                                                                                            |                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                            |  |                                                                                                                          |                                                                    |                                                                                                                                                            |                                                                                                 |                                                                                            |                                                 |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION<br><b>5-29-79</b>                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>PATHOLOGICAL FX L HIP</b>                                         |                                                                    |                                                                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                        |                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |                                                                                                 |                                                                                            |                                                 |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                   |                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |                                                                                                 |                                                                                            |                                                 |                                                                                                                            |                                              |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>5-27-79</b> to <b>6-22-79</b> , that (1) (we) lost saw the deceased alive on <b>6-22-79</b> 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                                              |  |                                                                                                                          |                                                                    |                                                                                                                                                            |                                                                                                 |                                                                                            |                                                 |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                          |                                                                    | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |                                                                                                 |                                                                                            |                                                 | 22c. DATE SIGNED                                                                                                           |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. GIDHAR</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                          |                                                                    | 22e. ADDRESS<br><b>GBMC</b>                                                                                                                                |                                                                                                 |                                                                                            |                                                 |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>6/26/1979</b>                                                                                            |                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem.Pk.</b>                                                                                            |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A.Co., Md.</b>              |                                                 |                                                                                                                            |                                              |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Geo. J. Gonce, 4001 Ritchie Hg., Baltimore</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                          |                                                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 27 1979</b>                                                                                                        |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                           |                                                 |                                                                                                                            |                                              |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR AT 15 ME (5))  
15M 7/77

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13680

|                                                                                                                                                                                                                                              |        |                                                                                                                                                                                                      |  |                                                                               |  |                                                                     |  |                                                               |  |                          |  |       |  |      |  |           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------------------------------------------------|--|--------------------------|--|-------|--|------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                          |        | FIRST                                                                                                                                                                                                |  | MIDDLE                                                                        |  | LAST                                                                |  | 2a. DATE KNOWN OF DEATH                                       |  | MONTH                    |  | DAY   |  | YEAR |  | 2b. HOUR  |  |
| Steven                                                                                                                                                                                                                                       |        | Scott                                                                                                                                                                                                |  | Holland                                                                       |  |                                                                     |  | 6-14 1979                                                     |  | 6                        |  | 14    |  | 1979 |  | 8:15 P.M. |  |
| 3 SEX                                                                                                                                                                                                                                        | 4 RACE | 5. DATE OF BIRTH                                                                                                                                                                                     |  | 6. AGE (IN YEARS)                                                             |  | IF UNDER 1 YR.                                                      |  | IF UNDER 24 HRS.                                              |  | 2c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR      |  |
| Male                                                                                                                                                                                                                                         | White  | March 2, 1967                                                                                                                                                                                        |  | 12 YRS.                                                                       |  |                                                                     |  |                                                               |  | 6/14 1979                |  | 6     |  | 14   |  | 1979      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                    |        | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                         |  | 8. MARRIED                                                                    |  | NEVER MARRIED                                                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                          |  |       |  |      |  |           |  |
| Maryland                                                                                                                                                                                                                                     |        | USA                                                                                                                                                                                                  |  | WIDOWED                                                                       |  | DIVORCED                                                            |  | Baltimore County                                              |  |                          |  |       |  |      |  | MD.       |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                    |        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                                               |  |                          |  |       |  |      |  |           |  |
| Middle River 21220                                                                                                                                                                                                                           |        | Strawberry Point                                                                                                                                                                                     |  | Student                                                                       |  | School                                                              |  |                                                               |  |                          |  |       |  |      |  |           |  |
| 13a. STATE                                                                                                                                                                                                                                   |        | 13b. COUNTY                                                                                                                                                                                          |  | 13c. CITY OR TOWN                                                             |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                                           |  |                          |  |       |  |      |  |           |  |
| Maryland                                                                                                                                                                                                                                     |        | Baltimore                                                                                                                                                                                            |  | Middle River                                                                  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 911 Cord Street 21220                                         |  |                          |  |       |  |      |  |           |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                            |        | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                             |  |                                                                               |  |                                                                     |  |                                                               |  |                          |  |       |  |      |  |           |  |
| James                                                                                                                                                                                                                                        |        | Holland                                                                                                                                                                                              |  | Janet                                                                         |  |                                                                     |  |                                                               |  |                          |  |       |  |      |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                 |        | 16b. SOCIAL SECURITY NO.                                                                                                                                                                             |  | 17. INFORMANT                                                                 |  | ADDRESS                                                             |  |                                                               |  |                          |  |       |  |      |  |           |  |
| No                                                                                                                                                                                                                                           |        | NONE                                                                                                                                                                                                 |  | James Holland                                                                 |  | Same                                                                |  |                                                               |  |                          |  |       |  |      |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                     |        | PART 1 DEATH WAS CAUSED BY:                                                                                                                                                                          |  | IMMEDIATE CAUSE (a)                                                           |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |                          |  |       |  |      |  |           |  |
| 9102                                                                                                                                                                                                                                         |        | Accidental Drowning                                                                                                                                                                                  |  |                                                                               |  |                                                                     |  |                                                               |  |                          |  |       |  |      |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                                                                |        | (b)                                                                                                                                                                                                  |  | DUE TO, OR AS A CONSEQUENCE OF                                                |  |                                                                     |  |                                                               |  |                          |  |       |  |      |  |           |  |
|                                                                                                                                                                                                                                              |        | (c)                                                                                                                                                                                                  |  |                                                                               |  |                                                                     |  |                                                               |  |                          |  |       |  |      |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                          |        |                                                                                                                                                                                                      |  |                                                                               |  |                                                                     |  |                                                               |  |                          |  |       |  |      |  |           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                       |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                    |  | 20. AUTOPSY?                                                                  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                               |  |                          |  |       |  |      |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                          |        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  | Drowning whilst swimming                                            |  |                                                               |  |                          |  |       |  |      |  |           |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                            |        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                                                          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  | Beach Strawberry Point Essex                                        |  |                                                               |  |                          |  |       |  |      |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: |        | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | TITLE (SPECIFY)                                                               |  |                                                                     |  |                                                               |  |                          |  |       |  |      |  |           |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                             |        | M.D.                                                                                                                                                                                                 |  | MEDICAL EXAMINER                                                              |  | DATE SIGNED                                                         |  | 6/14/79                                                       |  |                          |  |       |  |      |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                              |        | K.S. Ahluwalia, M.D.                                                                                                                                                                                 |  | 1221 Dundalk Ave                                                              |  | Dundalk, Md.                                                        |  |                                                               |  |                          |  |       |  |      |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                    |        | 23b. DATE                                                                                                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY                                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  | Burial 6-15-79 Holly Hill Cemetery Baltimore County, Maryland |  |                          |  |       |  |      |  |           |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                         |        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE                                                    |  |                                                                     |  | Brazdzinski Funeral Home PA 1407 Old Eastern Ave. JUN 14 1979 |  |                          |  |       |  |      |  |           |  |

08081 1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                          |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                          |                                                                                                 |                                               |                                                                                                                                       |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                           |  | FIRST<br>THERESA                                                                                                                                     |  | MIDDLE<br>E.                                                                                                                                                | LAST<br>HOLLAND                                          |                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6/1/79 |                                                                                                                                       | 2b. HOUR<br>3:25 AM                          |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>Cau                                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-1-83                                                                                                               |                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>95 YRS.                                                      |                                               | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                          |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |                                               |                                                                                                                                       |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baynesville                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Valley View Nursing Home                |  |                                                                                                                                                             |                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seafood Business            |                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |                                              |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br>Baltimore                                                                                                                             |  | 13c. CITY OR TOWN<br>Towson                                                                                                                                 |                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                               | 13e. STREET ADDRESS<br>1101 Gypsy Lane                                                                                                |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN |                                                                                                 |                                               |                                                                                                                                       |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-03-2551A                                                                              |  | 17. INFORMANT<br>ADDRESS<br>Fifi Reichhart Same as #13.                                                                                                     |                                                          |                                                                                                 |                                               |                                                                                                                                       |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CHF, decompensated<br>4379<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Cardiac arrhythmia<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                          |                                                                                                 |                                               |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):                                                                                                                                                                                                                          |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                          |                                                                                                 |                                               |                                                                                                                                       |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |  |                                                                                                                                                             |                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                          |                                                                                                 |                                               |                                                                                                                                       |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                          |                                                                                                 |                                               |                                                                                                                                       |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/1/79 to 6/1/79 that (I) (we) last saw the deceased alive on 6/1/79 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                          |                                                                                                 |                                               |                                                                                                                                       |                                              |
| 22b. SIGNATURE<br>Vuong Nguyen                                                                                                                                                                                                                                                                                                                                |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>6/2/79                                                                                                                                  |                                                          |                                                                                                 |                                               |                                                                                                                                       |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Vuong Nguyen                                                                                                                                                                                                                                                                                                         |  | 22e. ADDRESS<br>6 Linlow Court Balto Md 21204                                                                                                        |  |                                                                                                                                                             |                                                          |                                                                                                 |                                               |                                                                                                                                       |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br>June 4, 1979                                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery                                                                                                     |                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Balto., Md.                              |                                               |                                                                                                                                       |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                          | 25a. DATE REC'D. BY REGISTRAR<br>JUN 6 1979                                                     |                                               | 25b. REGISTRAR'S SIGNATURE<br>Kristy M. Brady                                                                                         |                                              |

BP

1800-1801







| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                 |  | KATHLEEN HOLMES                                                                                        |  |                                                                                                                                                          |  | 7 9 1 3 6 8 2                                                                                                           |  |                                                |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                       |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                                                                    |  | 2a. DATE OF DEATH MONTH DAY YEAR               |  |
| Kathleen                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  | Holmes                                                                                                                  |  | June 2, 1979                                   |  |
| 3. SEX                                                                                                                                                                                                                                                                                                 |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                         |  | 7b. HOUR                                       |  |
| Female                                                                                                                                                                                                                                                                                                 |  | White                                                                                                  |  | Dec. 25, 1911                                                                                                                                            |  | 67                                                                                                                      |  | 11:00 AM                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |  | 10. MONTHS DAYS HOURS MIN.                     |  |
| Virginia                                                                                                                                                                                                                                                                                               |  | USA                                                                                                    |  |                                                                                                                                                          |  | Baltimore County                                                                                                        |  |                                                |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |                                                |  |
| Towson                                                                                                                                                                                                                                                                                                 |  | St. Joseph Hospital                                                                                    |  | Homemaker                                                                                                                                                |  |                                                                                                                         |  |                                                |  |
| 13a. STATE                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS                            |  |
| Md.                                                                                                                                                                                                                                                                                                    |  | Balto.                                                                                                 |  | Towson                                                                                                                                                   |  |                                                                                                                         |  | 906 Dulaney Valley Courts-04                   |  |
| 14. FATHER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                |  | 17. INFORMANT ADDRESS                          |  |
| Arthur Lewis Mowbray                                                                                                                                                                                                                                                                                   |  | Claudia May Morris                                                                                     |  | no                                                                                                                                                       |  | 220-16-3300                                                                                                             |  | Mr. Jos. W. Holmes, Jr. 906 Dulaney Valley Ct. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 496- Chronic Obstructive Airway Disease                                                                                                                                       |  | (b)                                                                                                    |  | (c)                                                                                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |  | year                                           |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |  |                                                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-27-79 to 6-2-79, that (I) (we) lost saw the deceased alive on 6-2-79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.) |  | 22b. SIGNATURE (Type or Print) Robert Stoner, M.D.                                                     |  | 22c. DATE SIGNED 6-2-79                                                                                                                                  |  |                                                                                                                         |  |                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS                                                                                           |  | 23a. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23b. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |  |                                                |  |
|                                                                                                                                                                                                                                                                                                        |  | 7620 York Road, Towson Md. 21204                                                                       |  | Rose Hill Cem.                                                                                                                                           |  | Hagerstown, Md.                                                                                                         |  |                                                |  |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home                                                                                                                                                                                                                                                      |  | 24b. DATE 6/5/79                                                                                       |  | 24c. ADDRESS 6500 York Rd. Balto Md                                                                                                                      |  | 24d. DATE REC'D. BY REGISTRAR JUN 6 1979                                                                                |  | 24e. REGISTRAR'S SIGNATURE R. J. McCreedy      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2001 01



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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

7 9 1 3 6 8 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Mildred Laura Holmes</i>                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                      |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>June 29, 1979</i>                                        |                                                                                      | 2b. HOUR<br>M                                                                                                              |
| 3. SEX<br><i>female</i>                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><i>white</i>                                                                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>June 25, 1904</i>                                                                                                  |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>75</i>                     | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                  |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><i>Arbutus</i>                                                                                                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>5519 Link Avenue</i> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Supervisor</i>           | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Candy Mfg.</i>                               |                                                                                                                            |
| 13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                             | 13b. COUNTY<br><i>Baltimore</i>                                                                                                      | 13c. CITY OR TOWN<br><i>Arbutus</i>                                                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>5519 Link Avenue</i>                                       |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Herman E. Kale</i>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Tulula M. Smallwood</i>                                                                                 |                                                                                                 |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>215-05-3200</i>                                                                               |                                                                                                 | 17. INFORMANT ADDRESS<br><i>Mr. Kenneth G. Holmes 5519 Link Avenue</i>               |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><i>1551 Cholangio Carcinoma &amp; Metastases</i><br>IMMEDIATE CAUSE (a) <i>Cholangio Carcinoma &amp; Metastases</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>8 wks</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) |                                                                                                                                      |                                                                                                                                                             |                                                                                                 |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION<br><i>May 3-79</i>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Obstructive jaundice</i>                                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                          |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                              |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 1, 1979</i> to <i>May 12, 1979</i> , that (I) (we) lost<br>saw the deceased alive on <i>May 12, 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                          |                                                                                                                                      |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><i>Alfred S. Garrison</i>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      | DEGREE<br>ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>     |                                                                                                 | 22c. DATE SIGNED<br><i>June 29, 79</i>                                               |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Alfred S. Garrison, M.D.</i>                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                      | 22e. ADDRESS<br><i>3455 Wilkens Avenue 21229</i>                                                                                                            |                                                                                                 |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>burial</i>                                                                                                                                                                                                                                                                                                                                                             | 23b. DATE<br><i>7/2/79</i>                                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn Cemetery</i>                                                                                              |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Woodlawn Balto Md.</i>              |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Ambrose Funeral Home 1328 Sulphur Spring Rd.</i>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><i>JUL 2 1979</i>                                                                                                          |                                                                                                 | 25b. REGISTERED<br><i>Alfred Garrison</i>                                            |                                                                                                                            |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                      |  |                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Joanna E. Hoskins</b>                                                                                                                                                                                                                                                                                                                                |  | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>27</b> YEAR <b>79</b>                                                                                     |  | 2b. HOUR <b>7:58</b> MIN <b>P</b>                                                   |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 4 RACE<br><b>White</b>                                                                                                                               |  | 5 DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>16</b> YEAR <b>98</b>                      |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD. N/A/N/A</b>                                                                                                                                                                                                                                                                                                                              |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                                          |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS                                     |  |
| 10 CITY OR TOWN OF DEATH<br><b>Catonsville</b>                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>House in the Pines - Catonsville</b> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                   |  |
| 13a STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 13b COUNTY<br><b>Baltimore</b>                                                                                                                       |  | 13c CITY OR TOWN<br><b>Baltimore</b>                                                |  |
| 14 FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>Hoskins</b> LAST <b>Hoskins</b>                                                                                                                                                                                                                                                                                                              |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Barbara</b> MIDDLE <b>Easter</b> LAST <b>Easter</b>                                                              |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>none</b>      |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                               |  | 16b SOCIAL SECURITY NO.<br><b>216-46-0791 T</b>                                                                                                      |  | 17 INFORMANT<br>ADDRESS <b>21228</b><br><b>Grace B. Hoskins, 6023 Chesworth Rd.</b> |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Melanoma - Brain Bone</b><br>1919<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Diabetes Mellitus - Ch. 24 T. 7.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Alcohol - Asc - Pub - Dementia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                                      |  |                                                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                            |  |                                                                                                                                                      |  |                                                                                     |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                      |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                        |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                            |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                       |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6-14-79</b> , 19____, to <b>6-27-79</b> , 19____, that (I) (we) last saw the deceased alive on <b>6-26-79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.                                              |  |                                                                                                                                                      |  |                                                                                     |  |
| 22b SIGNATURE<br><b>George Anquor</b>                                                                                                                                                                                                                                                                                                                                                          |  | DEGREE                                                                                                                                               |  | 22c DATE SIGNED                                                                     |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE ANQUOR</b>                                                                                                                                                                                                                                                                                                                                   |  | 22e ADDRESS<br><b>3350 Wilkins Dr. - Baltimore</b>                                                                                                   |  |                                                                                     |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                   |  | 23b DATE<br><b>6/30/79</b>                                                                                                                           |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                    |  |
| 23d LOCATION<br>CITY OR TOWN<br><b>Baltimore,</b>                                                                                                                                                                                                                                                                                                                                              |  | COUNTY<br><b>Maryland</b>                                                                                                                            |  | STATE                                                                               |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Witzke Catonsville Funeral Home, P.A. 21228</b>                                                                                                                                                                                                                                                                                                              |  | DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                                                                                        |  | 25 REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                      |  |

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Mr. J. H. A. ...  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 10 days after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13685

|                                                                                                                                                                                                                                                                                                           |  |                                                                              |      |                                                                                                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------|-------------------------------------------------------------------------------------------------------------------------|-----------|---------------------------------------------------------------------|-------|----------------------------------------------------------------------|--------|----------------------------------------------|--------------------|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                       |  | First                                                                        | MARY | Middle                                                                                                                  | ELIZABETH | Last                                                                | HUBER | 2a. DATE OF DEATH                                                    |        | 2b. HOUR                                     |                    |
|                                                                                                                                                                                                                                                                                                           |  |                                                                              |      |                                                                                                                         |           |                                                                     |       | 6 Month                                                              | 28 Day | 79 Year                                      | 12 <sup>30</sup> M |
| 3. SEX                                                                                                                                                                                                                                                                                                    |  | 4. RACE                                                                      |      | 5. DATE OF BIRTH                                                                                                        |           | 6. AGE (In years last birthday)                                     |       | IF UNDER 1 YEAR                                                      |        | IF UNDER 24 HRS.                             |                    |
| Female                                                                                                                                                                                                                                                                                                    |  | white                                                                        |      | 8-25-1890                                                                                                               |           | 88 YRS.                                                             |       | MONTHS                                                               |        | DAYS                                         |                    |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |      | 8. MARRIED                                                                                                              |           | 9. COUNTY OF DEATH                                                  |       |                                                                      |        |                                              |                    |
| Md                                                                                                                                                                                                                                                                                                        |  | USA                                                                          |      | NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |           | BALTO, CO.                                                          |       |                                                                      |        |                                              |                    |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                 |           | 12b. KIND OF BUSINESS OR INDUSTRY                                   |       |                                                                      |        |                                              |                    |
| Catonsville                                                                                                                                                                                                                                                                                               |  | 6004 EDMONDSON                                                               |      | Housewife                                                                                                               |           |                                                                     |       |                                                                      |        |                                              |                    |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                             |  | 13b. COUNTY                                                                  |      | 13c. CITY OR TOWN                                                                                                       |           | 13d. INSIDE CITY LIMITS?                                            |       | 13e. STREET AND NUMBER                                               |        |                                              |                    |
| MD                                                                                                                                                                                                                                                                                                        |  | BALTO                                                                        |      | Catonsville                                                                                                             |           | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       | 6004 EDMONDSON                                                       |        | 21228                                        |                    |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME                                                     |      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)                                                      |           | 16b. SOCIAL SECURITY NO.                                            |       | 17. INFORMANT                                                        |        | Address                                      |                    |
| First Middle Last                                                                                                                                                                                                                                                                                         |  | First Middle Last                                                            |      | NO                                                                                                                      |           | 800 05 3213                                                         |       | ANN LUGOWSKI                                                         |        | Same                                         |                    |
| GEORGE                                                                                                                                                                                                                                                                                                    |  | HIBBITTS                                                                     |      | MARY                                                                                                                    |           | ENZABETH                                                            |       | ROACH                                                                |        |                                              |                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                 |  | 19. DATE OF OPERATION                                                        |      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                        |           | 20a. AUTOPSY?                                                       |       | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                    |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292                                                                                                                                                                                                                                                  |  |                                                                              |      |                                                                                                                         |           | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       |                                                                      |        | Added                                        |                    |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                            |  |                                                                              |      |                                                                                                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                                                                                                            |  |                                                                              |      |                                                                                                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
| (b)                                                                                                                                                                                                                                                                                                       |  |                                                                              |      |                                                                                                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                            |  |                                                                              |      |                                                                                                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
| (c)                                                                                                                                                                                                                                                                                                       |  |                                                                              |      |                                                                                                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                       |  |                                                                              |      |                                                                                                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
| Arteriosclerosis diabetes mellitus                                                                                                                                                                                                                                                                        |  |                                                                              |      |                                                                                                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                        |  | 21b. TIME OF INJURY                                                          |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
|                                                                                                                                                                                                                                                                                                           |  | HOUR A.M. Month Day Year                                                     |      |                                                                                                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
| P.M. 19                                                                                                                                                                                                                                                                                                   |  |                                                                              |      |                                                                                                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.  |      | 21f. LOCATION                                                                                                           |           | Street or R.F.D. No.                                                |       | City or Town                                                         |        | County State                                 |                    |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                       |  |                                                                              |      |                                                                                                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-25, 1958, to 6-28, 1979, that (I) (we) last saw the deceased alive on 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                              |      |                                                                                                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                            |  | 22c. DATE SIGNED                                                             |      | 22d. PHYSICIAN'S NAME (Type)                                                                                            |           | 22e. ADDRESS                                                        |       |                                                                      |        |                                              |                    |
| John F. Schaefer MD                                                                                                                                                                                                                                                                                       |  | 6-28-79                                                                      |      | JOHN F. SCHAEFER M.D.                                                                                                   |           | 5550 BALTO, NATH PIKE                                               |       |                                                                      |        |                                              |                    |
|                                                                                                                                                                                                                                                                                                           |  |                                                                              |      |                                                                                                                         |           |                                                                     |       |                                                                      |        |                                              |                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                 |  | 23b. DATE                                                                    |      | 23c. NAME OF CEMETERY OR CREMATORY                                                                                      |           | 23d. LOCATION (City or Town)                                        |       | (County)                                                             |        | (State)                                      |                    |
| Burial                                                                                                                                                                                                                                                                                                    |  | 6/30/79                                                                      |      | New Cathedral Cemetery                                                                                                  |           | Baltimore,                                                          |       |                                                                      |        | Maryland                                     |                    |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                      |  | 25a. REC'D BY REGISTRAR                                                      |      | 25b. REGISTRAR'S SIGNATURE                                                                                              |           |                                                                     |       |                                                                      |        |                                              |                    |
| 1630 Edmondson Ave., Catonsville, MD                                                                                                                                                                                                                                                                      |  | JUL 3 1979                                                                   |      | Witzke Catonsville Funeral Home, P.A. 21228                                                                             |           |                                                                     |       |                                                                      |        |                                              |                    |



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Samuel

S

Hudnet

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

June 16th 1979

7:20 A.M.

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

June 26 1910

6. AGE (IN YEARS LAST BIRTHDAY)

68

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County

MD.

10. CITY OR TOWN OF DEATH

Towson

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
St. Joseph Hospital

12a. USUAL OCCUPATION

Fireman

12b. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Essex 21221

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

329 Taylor Ave.

14. FATHER'S NAME

August R. Hudnet

LAST

15. MOTHER'S MAIDEN NAME

Florence V. Davis

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)  
No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)  
215 05 4507

17. INFORMANT

ADDRESS

Marie E. Hudnet, Wife

Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Carcinomatosis

DUE TO, OR AS A CONSEQUENCE OF

(c) Carcinoma Colon

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (this hospital) attended the deceased from 4-15, 19 79, to 6-16, 19 79, that (we) lost  
saw the deceased alive on 6-16, 19 79, and that in (our) opinion death occurred on the date and hour and from the causes stated  
above, (we) (did) (did not) view the body after death.

22b. SIGNATURE

Herminio P. Anjo

DEGREE

ATTENDING  
PHYSICIAN ☐MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☒

22c. DATE SIGNED

6-16-79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Herminio P. Anjo, M.D.

22e. ADDRESS

7620 York Road, Towson, Md. 21204

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

6/19/79

23c. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

23d. LOCATION

Baltimore, Md.

COUNTY STATE

24. FUNERAL DIRECTOR

Brazdzinski Funeral Home PA 1407 Old Eastern Ave

25a. DATE REC'D. BY REGISTRAR

JUN 20 1979

25b. REGISTRAR'S SIGNATURE

Anthony McBrady

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Journal of Management Education 32(1)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                              |  |                                                                                                                                                             |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                 |  | 7 9 1 3 6 8 7                                                                                                                |  | REG. NO.                                                                                                                                                    |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Evelyn R Hummel                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                              |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 9, 1979                                                                                                            |                                                                                      | 2b. HOUR<br>1:45AM                                                         |                                                                                                                            |                                                                                                 |                                              |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>W                                                                                                                 |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 27 21                                                                                                                  |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS                                  |                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                       |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.              |                                                                                                                            |                                                                                                 |                                              |
| 10. CITY OR TOWN OF DEATH<br>ESSEX                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQ. HOSP. |  |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>POL.-Seal |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                                                          |                                              |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                              |  | 13b. COUNTY<br>BALTO.                                                                                                                                       |                                                                                      | 13c. CITY OR TOWN<br>ESSEX                                                 |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Wooden                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>PAULINE FAUTH                                                                                                 |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>-                                                                                                |  | 17. INFORMANT ADDRESS<br>JOSEPH HUMMEL ABOVE                                                                                                                |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable Acute Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |                                                                                                                              |  |                                                                                                                                                             |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                   |  |                                                                                                                              |  |                                                                                                                                                             |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                             |  |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |                                              |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>May 18,</u> 19 <u>79</u> , to <u>June 9,</u> 19 <u>79</u> , that (X) (we) last saw the deceased alive on <u>June 9,</u> 19 <u>79</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (not) view the body after death.                                       |  |                                                                                                                              |  |                                                                                                                                                             |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |                                              |
| 22b. SIGNATURE<br><i>R. Gomez</i>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                              |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                      | 22c. DATE SIGNED<br>6/9/79                                                 |                                                                                                                            |                                                                                                 |                                              |
| 22d. PHYSICIAN'S NAME<br>R. Gomez, M.D.                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                              |  | 22e. ADDRESS<br>9000 Franklin Square Drive 21237                                                                                                            |                                                                                      |                                                                            |                                                                                                                            |                                                                                                 |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>6/12/79                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN                                                                                                              |                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>ESSEX BALTO. MD.                |                                                                                                                            |                                                                                                 |                                              |
| 24. FUNERAL DIRECTOR NAME<br>CONNELLY F.H.                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                              |  | ADDRESS<br>300 MACE AVE                                                                                                                                     |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br>JUN 14 1979                               |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><i>John McCreedy</i>                                              |                                              |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

13688

|                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                             |                          |                                                                                                                                                             |                                                                     |                                                                     |                                                                      |                                          |                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                             | First                    | Middle                                                                                                                                                      | Last                                                                | 2a. DATE OF DEATH                                                   |                                                                      | 2b. HOUR                                 |                                                                                      |
| IDA K. HUNT                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                             |                          |                                                                                                                                                             |                                                                     | June 12, 1979                                                       |                                                                      | 10:45 PM                                 |                                                                                      |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE                                                                                     |                          | 5. DATE OF BIRTH                                                                                                                                            |                                                                     | 6. AGE (In years lost birthday)                                     |                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |                                                                                      |
| Female                                                                                                                                                                                                                                                                                                                                                                                     |  | White                                                                                       |                          | June 2, 1889                                                                                                                                                |                                                                     | 90 YRS                                                              |                                                                      |                                          |                                                                                      |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. COUNTY OF DEATH                                                  |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY        |                                                                                      |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                   |  | U.S.A.                                                                                      |                          |                                                                                                                                                             |                                                                     | Baltimore                                                           |                                                                      | Dept. Store                              |                                                                                      |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)                |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                     |                                                                     |                                                                     |                                                                      |                                          |                                                                                      |
| Catonsville                                                                                                                                                                                                                                                                                                                                                                                |  | Summit Nursing Home                                                                         |                          | Sales Lady                                                                                                                                                  |                                                                     |                                                                     |                                                                      |                                          |                                                                                      |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                 |                          | 13c. CITY OR TOWN                                                                                                                                           |                                                                     | 13d. INSIDE CITY LIMITS?                                            |                                                                      | 13e. STREET AND NUMBER                   |                                                                                      |
| Md.                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                             |                          | Baltimore                                                                                                                                                   |                                                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                      | 3129 Strickland St.                      |                                                                                      |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                             | First                    | Middle                                                                                                                                                      | Last                                                                | 15. MOTHER'S MAIDEN NAME                                            |                                                                      |                                          | First Middle Last                                                                    |
| Adam I. Leithauser                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                             |                          |                                                                                                                                                             |                                                                     | Christina Haas                                                      |                                                                      |                                          |                                                                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)                                                                                                                                                                                                                                                                                                                      |  |                                                                                             | 16b. SOCIAL SECURITY NO. |                                                                                                                                                             | 17. INFORMANT Address                                               |                                                                     |                                                                      |                                          |                                                                                      |
| No                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                             |                          |                                                                                                                                                             | Mrs. Margaret E. Quoss Strickland St. 3220                          |                                                                     |                                                                      |                                          |                                                                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ARTERIO SCLEROSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>4409</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                             |                          |                                                                                                                                                             |                                                                     |                                                                     |                                                                      |                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>30 MINUTES</u><br><u>10 YEARS</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>DIABETES MELLITUS</u>                                                                                                                                                                                                                             |  |                                                                                             |                          |                                                                                                                                                             |                                                                     |                                                                     |                                                                      |                                          |                                                                                      |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                            |                          |                                                                                                                                                             | 20a. AUTOPSY?                                                       |                                                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                          |                                                                                      |
| 3/6/79                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                             |                          |                                                                                                                                                             | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                     |                                                                      |                                          |                                                                                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. 3 P.M. 3 Month 3 Year 1979                                 |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><u>FELL ON FLOOR AT HOME</u>                                             |                                                                     |                                                                     |                                                                      |                                          |                                                                                      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br><u>Home</u> |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                                                     | 3220 Strickland St Baltimore Md 21229                               |                                                                      |                                          |                                                                                      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>76</u> , to <u>6/12</u> , 19 <u>79</u> , that (I) (we) lost the deceased on <u>6/29</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                    |  |                                                                                             |                          |                                                                                                                                                             |                                                                     |                                                                     |                                                                      |                                          |                                                                                      |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                             |  | 22c. DATE SIGNED                                                                            |                          |                                                                                                                                                             |                                                                     | 22d. PHYSICIAN'S NAME (Type)                                        |                                                                      |                                          |                                                                                      |
| Paul R. Ziegler                                                                                                                                                                                                                                                                                                                                                                            |  | 6/13/1979                                                                                   |                          |                                                                                                                                                             |                                                                     | PAUL R. ZIEGLER                                                     |                                                                      |                                          |                                                                                      |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                               |  | 22e. ADDRESS                                                                                |                          | 22c. DATE SIGNED                                                                                                                                            |                                                                     |                                                                     |                                                                      |                                          |                                                                                      |
| PAUL R. ZIEGLER                                                                                                                                                                                                                                                                                                                                                                            |  | 2902 Chestnut Hill OR EC. Md                                                                |                          | 6/13/1979                                                                                                                                                   |                                                                     |                                                                     |                                                                      |                                          |                                                                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE                                                                                   |                          | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                     | 23d. LOCATION (City or Town) (County) (State)                       |                                                                      |                                          |                                                                                      |
| Burial                                                                                                                                                                                                                                                                                                                                                                                     |  | 6/15/1979                                                                                   |                          | Mount Olivet                                                                                                                                                |                                                                     | Baltimore, Maryland                                                 |                                                                      |                                          |                                                                                      |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                       |  | ADDRESS                                                                                     |                          | 25a. REC'D BY REGISTRAR                                                                                                                                     |                                                                     | 25b. REGISTRAR'S SIGNATURE                                          |                                                                      |                                          |                                                                                      |
| G. Truman Schwab                                                                                                                                                                                                                                                                                                                                                                           |  | 3512 Frederick Ave.                                                                         |                          | 21229                                                                                                                                                       |                                                                     | JUN 28 1979                                                         |                                                                      |                                          |                                                                                      |

25b. REGISTRAR'S SIGNATURE  
*Anthony McBrady*



88031 1 2 3 4 5 6 7 8 9 0



IN THE COURT OF THE DISTRICT OF COLUMBIA

JUNE 8 1900



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                                                                           |                                                                                    |                                                                                                 |                                                                |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Philip Joseph HUPKA</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 13, 1979</b>            |                                                                                                                                                             |                                                                                                                                           | 2b. HOUR<br>M<br><b>AM</b>                                                         |                                                                                                 |                                                                |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>White</b>                                                                                                                      |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 12, 1913</b>                                                                                                  |                                                                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS                                   |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County,</b> MD.               |                                                                                                 |                                                                |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Valley View Nursing Home</b> |                                                                        |                                                                                                                                                             |                                                                                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Milkman</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dairy</b>              |                                                                                                                            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              | 13b. COUNTY<br><b>Baltimore</b>                                        |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>21234</b>                                                                                                         |                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                | 13e. STREET ADDRESS<br><b>8540 Willow Oak Road</b>                                                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jospeh Hupka</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Antoinette Krepska</b>                                                                                  |                                                                                                                                           |                                                                                    |                                                                                                 |                                                                |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                    |  |                                                                                                                                              | 16b. SOCIAL SECURITY NO.<br><b>218-05-2557</b>                         |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Helen S. Hupka 21234 8540 Willow Oak Rd.</b>                                                               |                                                                                    |                                                                                                 |                                                                |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause primary for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CVA</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Advanced Age</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                                                                           |                                                                                    |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |                                                                                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Death for others.</b>                                                                                                                                                                                                   |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                                                                           |                                                                                    |                                                                                                 |                                                                |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                           |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                         |  |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                            |                                                                                    |                                                                                                 |                                                                |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                        |  |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                         |                                                                                    |                                                                                                 |                                                                |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |                                                                                                                                              |                                                                        |                                                                                                                                                             |                                                                                                                                           |                                                                                    |                                                                                                 |                                                                |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Gracito Patricio</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |                                                                        |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                    |                                                                                                 | 22c. DATE SIGNED<br><b>6/14/79</b>                             |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gracito Patricio, M.D.</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>2926 E. Cold Spring Lane 254-0392</b>                                                                                  |                                                                                    |                                                                                                 |                                                                |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              | 23b. DATE<br><b>June 16, '79</b>                                       |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk. Howard County, Md.</b>                                                      |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |                                                                |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William E. Johnson 8521 Loch Raven Blvd</b>                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>                                                                                       |                                                                                    | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                |                                                                |                                                                                                                            |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13284



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN THIS CERTIFICATE FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/76

| Items 21f. Film G533 DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                     |  |                      |  |                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                          |  | Items 20. Film G533 7-12-79 as 13690                                   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7-5-79 as            |  | REG. NO.                                                                                                                       |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                        |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>DAVID BARRY HURWITZ</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                      |  |                                                                                                                                |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>6</b> DAY <b>20</b> YEAR <b>1979</b> |  | 2b. HOUR <b>12:12</b>                                                                                                                                    |  | 2c. DATE PRONOUNCED DEAD <b>6 20 79</b>                                |  |
| 3. SEX <b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE <b>white</b> |  | 5. DATE OF BIRTH (MONTH DAY YEAR) <b>JAN. 18, 1954</b>                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>25</b> YRS                                                             |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                                                                                                                    |  | 7c. DATE PRONOUNCED DEAD <b>6 20 79</b>                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                        |  |                                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>           |  |
| 10. CITY OR TOWN OF DEATH <b>OWINGS MILLS</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2914 Caves Road</b> |  |                                                                                                           |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>TRUCKS</b>                        |  |
| 13a. STATE <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                      |  | 13b. COUNTY <b>BALTO.</b>                                                                                                      |  | 13c. CITY OR TOWN <b>BALTIMORE</b>                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 13e. STREET ADDRESS <b>APT. 2-B 19 WARREN PARK CT. #21208</b>          |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>REUBEN HURWITZ</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                      |  |                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>BERNICE MOTZNO</b>                                        |  |                                                                                                                                                          |  |                                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                                             |  |                      |  | 16b. SOCIAL SECURITY NO.                                                                                                       |  | 17. INFORMANT <b>REUBEN HURWITZ</b>                                                                       |  |                                                                                                                                                          |  | 17. ADDRESS <b>1 E. CHASE ST., APT. 505 #21202</b>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <b>Gunshot wound of head</b><br><b>9554</b> IMMEDIATE CAUSE (a) <b>9554</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>                                                          |  |                      |  |                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |  |                      |  |                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                              |  |                                                                                                           |  | 20. AUTOPSY? (Head only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |                                                                        |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                           |  |                      |  | 21b. TIME OF INJURY <b>12:00 PM 6 19 79</b>                                                                                    |  |                                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self inflicted</b>                                                      |  |                                                                        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                        |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>                                                        |  |                                                                                                           |  | 21f. LOCATION <b>2914 Caves Road</b> CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE                                                          |  |                                                                        |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                        |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                      |  |                                                                                                                                |  | TITLE (SPECIFY) <b>Assistant</b>                                                                          |  | DATE SIGNED <b>6/20/79</b>                                                                                                                               |  | M.D. <b>Assistant</b> MEDICAL EXAMINER                                 |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                      |  |                                                                                                                                |  | ADDRESS <b>111 Penn Street</b>                                                                            |  |                                                                                                                                                          |  |                                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                      |  | 23b. DATE <b>JUNE 21, 1979</b>                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY <b>OHEB SHALOM MEM. PARK</b>                                           |  |                                                                                                                                                          |  | 23d. LOCATION <b>REISTERSTOWN</b> COUNTY <b>BALTO.</b> STATE <b>MD</b> |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                      |  |                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>                                                          |  | 25b. SIGNATURE <b>[Signature]</b>                                                                                                                        |  |                                                                        |  |
| NAME <b>6010 REISTERSTOWN RD.</b> ADDRESS <b>BALTO., MD 21215</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                      |  |                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                        |  |

08001

(M)

Approved by Special Agent

Special Agent in Charge

Special Agent in Charge

RECEIVED

10000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 13691

1- FOR  
STATE  
REGISTRAR

|                                                                                |  |                                                                                                                                      |                                                                 |                                                                                                                                                             |                                                                           |                                                                                           |                                                                                      |                                                                |                                                          |  |
|--------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JALIL</b> <b>HANNA Jabaji</b>           |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 10 79</b>           |                                                                                                                                                             |                                                                           | 2b. HOUR<br><b>7:30 A.M.</b>                                                              |                                                                                      |                                                                |                                                          |  |
| 3. SEX<br><b>M</b>                                                             |  | 4. RACE<br><b>WHITE</b>                                                                                                              |                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 17 1908</b>                                                                                                      |                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                         |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PALESTINE</b>                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Jordan</b>                                                                                        |                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                       |                                                                                      |                                                                |                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5324 Litney Lane</b> |                                                                 |                                                                                                                                                             |                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Postal Manager</b> |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                                          |  |
| 13a. STATE<br><b>California</b>                                                |  |                                                                                                                                      | 13b. COUNTY<br><b>Sun Valley</b>                                |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Sun Valley</b>                                    |                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                | 13e. STREET ADDRESS<br><b>10707 New Haven St. Apt 37</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hanna Jabaji</b>                  |  |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b> |                                                                                                                                                             |                                                                           |                                                                                           |                                                                                      |                                                                |                                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> |  |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>571-43-2910</b>                  |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Dr. George Jalil Jabaji 5324 Litney Ln</b> |                                                                                           |                                                                                      |                                                                |                                                          |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4140**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.**Cardiac arrhythmia**  
**Coronary heart disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**> 3 yrs.**

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**NONE**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION  
**1/9/75**19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
**Coronary bypass for coronary disease**20a. AUTOPSY?  
YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
**P.M. 19**

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from  
the date of death or the date of admission (I) (we) (did) (did not) view the body after death.19 **5/28 79**, to **6/6 79**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

**ERNEST N. HARNETT****9101 FRANKLIN SQUARE DRIVE**23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION  
CITY OR TOWN

COUNTY

STATE

**Burial**24. FUNERAL DIRECTOR  
NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

**LASSIAHN F. H. 7461****DELAIR****JUN 13 1979****Anthony MacBrady****Calif.**TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 8 0 2 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-2222.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                      |                                                                             |                                                                                                                                                             |                                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Artus James</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 19, 1979</b>                 |                                                                                                                                                             |                                                                        | 2b. HOUR<br><b>4:30 P.M.</b>                                                                                                               |                                                                                                 |                                                                                                                            |                                                |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>White</b>                                                                                                              |                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 27, 1891</b>                                                                                                  |                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS                                                                                           |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                        |                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                                                                       |                                                                                                 |                                                                                                                            |                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>21212</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>909 Old Oak Road</b> |                                                                             |                                                                                                                                                             |                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Social Worker</b>                                                   |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Charity</b>                                                                        |                                                |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      | 13b. COUNTY<br><b>Baltimore</b>                                             |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>21212</b>                                      |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>909 Old Oak Road</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard I. James</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen B. Overbacher</b> |                                                                                                                                                             |                                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>220-30-1209</b>                              |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>John D. Burke 104 E. Montgomery St.</b> |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4409 Hemorrhage - GI Tract</b><br>IMMEDIATE CAUSE (a) <b>Hemorrhage - GI Tract</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Generalized Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                      |                                                                             |                                                                                                                                                             |                                                                        |                                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.<br><b>Severe hyperlipidemic arthritis spine; Osteoporosis</b>                                                                                                                                                                                                                         |  |                                                                                                                                      |                                                                             |                                                                                                                                                             |                                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                |  |
| 19a. DATE OF OPERATION<br><b>6/23/79</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |                                                                                                                                                             |                                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                |  |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |                                                                                                                                                             |                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                 |                                                                                                                            |                                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |                                                                                                                                                             |                                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                 |                                                                                                                            |                                                |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>6/19/79</b> to <b>6/20/79</b> , that (1) (we) lost<br>saw the deceased alive on <b>6/19/79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death.                                                                                        |  |                                                                                                                                      |                                                                             |                                                                                                                                                             |                                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                |  |
| 22b. SIGNATURE<br><b>Walter B. Buck</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      | DEGREE<br><b>M.D.</b>                                                       |                                                                                                                                                             |                                                                        | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>6/21/79</b>                                                                                         |                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER B. BUCK</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      | 22e. ADDRESS<br><b>201 E. UNIV. PKWY BALTO 21218</b>                        |                                                                                                                                                             |                                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      | 23b. DATE<br><b>6/23/79</b>                                                 |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cave Hill Cemetery</b>        |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Louisville, Kentucky</b>                       |                                                                                                                            |                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William E. Johnson 8521 Loch Raven Rd.</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |                                                                             |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>                    |                                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>Fitzpatrick</b>                                                |                                                                                                                            |                                                |  |

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*Handwritten signature or initials.*

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 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

9 1 3 6 9 3

 FOR  
 1 - STATE  
 REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                   |  |                                                                                                 |                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY A. JANDA MIDDLE JANDA LAST JANDA                                                                                                                                                                                                                                                                                |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 8, 1979                                                                               |  | 2b. HOUR<br>6:20A <sup>M</sup>                                                                  |                                                         |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>White                                                                                                                  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 9, 1894                                              |                                                         |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84<br>YRS. MONTHS DAYS HOURS MIN                             |                                                         |
| 10. CITY OR TOWN OF DEATH<br>Chase                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>12908 Community Road |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |                                                         |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                            |  | 13b. COUNTY<br>Baltimore                                                                                                          |  | 13c. CITY OR TOWN<br>CHASE                                                                      |                                                         |
| 14. FATHER'S NAME<br>FIRST John MIDDLE JANDA LAST JANDA                                                                                                                                                                                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Antonia MIDDLE KAKUSKA LAST KAKUSKA                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>2131098470                                                                                            |  | 17. INFORMANT<br>Joseph Janda 12908 Community Road                                              |                                                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebro Vascular disease<br>4379<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                   |  |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 mos + |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>None                                                                                                                                                                                                                      |  |                                                                                                                                   |  |                                                                                                 |                                                         |
| 19a. DATE OF OPERATION<br>None                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                         |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>apile                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>6/8/79                                     |                                                         |
| 22a. I certify that (1) (this hospital) attended the deceased from 6/6/79 to 6/8/79, that (1) (we) lost saw the deceased alive on 6/6/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) did not view the body after death.                                                                   |  |                                                                                                                                   |  |                                                                                                 |                                                         |
| 22b. SIGNATURE<br>Bernard J. Yukna M.D.                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  | 22c. DATE SIGNED<br>6-8-79                                                                      |                                                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BERNARD J. YUKNA, M.D., A.B.F.P.                                                                                                                                                                                                                                                                                         |  |                                                                                                                                   |  | 22e. ADDRESS<br>404 BOWLEYS QUARTERS ROAD/BALTO20                                               |                                                         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br>6-11-79                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Church                                      |                                                         |
| 24. FUNERAL DIRECTOR<br>NAME<br>Theresa L. 1211 Chase Ave.                                                                                                                                                                                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 12 1979                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br>Theresa L. 1211 Chase Ave.                                        |                                                         |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County Maryland                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  |                                                                                                 |                                                         |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

C. C. C. C. C. C. C.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                        |  |                                                                                                                                        |                                                      |                                                                                                                                                             |  |                                                                                      |  |
|----------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Missouri E. JOHNSON</b> |  |                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 5 79</b> |                                                                                                                                                             |  | 2b. HOUR<br>a<br><b>8:40 M</b>                                                       |  |
| 3. SEX<br><b>Female</b>                                                                |  | 4. RACE<br><b>Black</b>                                                                                                                |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 24 1893</b>                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>85</b>                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balt. Md.</b>                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                           |                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Sq. Hosp.</b> |                                                      |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  |
| 13a. STATE<br><b>Md.</b>                                                               |  |                                                                                                                                        |                                                      | 13b. COUNTY<br><b>BALTO.</b>                                                                                                                                |  | 13c. CITY OR TOWN                                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William</b>                               |  |                                                                                                                                        |                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clementine</b>                                                                                          |  |                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>      |  |                                                                                                                                        |                                                      | 16b. SOCIAL SECURITY NO.<br><b>212-18-7321</b>                                                                                                              |  | 17. INFORMANT<br>ADDRESS<br><b>Francine Thompson 1643 Hopewell Ave.</b>              |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **Cardio-pulmonary arrest**

**586-**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF  
(b) **Metabolic acidosis**  
DUE TO, OR AS A CONSEQUENCE OF  
(c) **Renal Failure**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

**Congestive Heart Failure; probable gall bladder disease**

|                                                                                                                                                                                                                                                                                                                                          |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/24/ 19 79</b> , to <b>6/5/ 19 79</b> , that (I) (we) last saw the deceased alive on <b>6/5/ 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Barbara Pary</b>                                                                                                                                                                                                                                                                                                    |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/5/79</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARBARA PAREY M.D.</b>                                                                                                                                                                                                                                                                       |  |                                                                        |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive</b>                                                                                                    |  |                                                                                                                            |  |

|                                                                                       |  |                            |  |                                                                  |  |                                                                 |  |
|---------------------------------------------------------------------------------------|--|----------------------------|--|------------------------------------------------------------------|--|-----------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                            |  | 23b. DATE<br><b>6-8-79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William C. Brown 1206-08 W. North Ave.</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>              |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                             |  |                                               |  |                                                                                                                                                         |  |                                                                                                                                                                                      |  |                                                                                                                     |  | 1 3 6 9 5<br>REG. NO.                                                                                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SAMUEL MOTTOMORS Johnson</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                               |  |                                                                                                                                                         |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 19 <input type="checkbox"/> 79 |  |                                                                                                                     |  | 2b. HOUR <input type="checkbox"/> 4 <input type="checkbox"/> 7 <input type="checkbox"/> M                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>Black</b>                       |  | 5. DATE OF BIRTH<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 19 <input type="checkbox"/> 79            |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <input type="checkbox"/> YRS. <input type="checkbox"/> 67                                                                                         |  | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. |  | 7c. DATE PRONOUNCED DEAD<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 19 <input type="checkbox"/> 79 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Orangeburg, S.C.</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |                                                                                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balti-Country</b> MD.                                                    |  |                                                                                                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4411 Spring Ave. (Halethorpe, Md.)</b> |  |                                                                                                                                                                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Retired Baltimore G&amp;E Co.</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                    |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                               |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                         |  | 13c. CITY OR TOWN<br><b>Halethorpe</b>                                                                                                                                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET ADDRESS<br><b>4411 Sping Ave. 21227</b>                                                                                                  |  |
| 14. FATHER'S NAME<br>FIRST <b>Wesley</b> MIDDLE <b>Johnson</b> LAST                                                                                                                                                                                                                                                                                                                                                                                 |  |                                               |  |                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lorraine</b> MIDDLE <b>Johnson</b> LAST                                                                                                         |  |                                                                                                                     |  |                                                                                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                                                                                          |  |                                               |  | 16b. SOCIAL SECURITY NO.<br><b>215-01-6273</b>                                                                                                          |  | 17. INFORMANT ADDRESS<br><b>Lorraine Johnson, Wife 4411 Spring Ave.</b>                                                                                                              |  |                                                                                                                     |  |                                                                                                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASCVD</b><br><b>4939</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>BRONCHIAL ASTHMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                 |  |                                               |  |                                                                                                                                                         |  |                                                                                                                                                                                      |  |                                                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 YEARS</b><br><b>YEARS</b>                                                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDIION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                  |  |                                               |  |                                                                                                                                                         |  |                                                                                                                                                                                      |  |                                                                                                                     |  |                                                                                                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                       |  |                                                                                                                                                                                      |  |                                                                                                                     |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                             |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                 |  |                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                        |  |                                                                                                                     |  |                                                                                                                                                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                     |  |                                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                    |  |                                                                                                                     |  |                                                                                                                                                      |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> . |  |                                               |  |                                                                                                                                                         |  |                                                                                                                                                                                      |  |                                                                                                                     |  |                                                                                                                                                      |  |
| ACTUAL SIGNATURE<br><b>E. P. Williamson II</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                               |  | TITLE (SPECIFY)<br><b>Deputy</b>                                                                                                                        |  |                                                                                                                                                                                      |  | MEDICAL EXAMINER<br>DATE SIGNED <b>6-4-79</b>                                                                       |  |                                                                                                                                                      |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>E. P. Williamson II</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                               |  | ADDRESS<br><b>5550 BALTO NAT'L PIKE</b>                                                                                                                 |  |                                                                                                                                                                                      |  |                                                                                                                     |  |                                                                                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                               |  | 23b. DATE<br><b>6/8/79</b>                                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>                                                                                                                       |  |                                                                                                                     |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltijmore</b> COUNTY <b>1222</b> STATE <b>Maryland</b>                                                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>law Funeral Home 4611 Park Hdights Ave. 21215</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                               |  |                                                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>5 JUN 6 1979</b>                                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>Pitney McBrady</b>                                                                 |  |                                                                                                                                                      |  |

MEDICAL CERTIFICATION

2000

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[illegible][illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                              |  |                                                  |  |                                    |  |                                                                     |  |                                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|--|------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                            |  | 1. DECEASED NAME (TYPE OR PRINT)                 |  | 2. DATE OF DEATH                   |  | 3. SEX                                                              |  | 4. RACE                                                        |  |
|                                                                                                                                                                                                                                                                                                                   |  | FREDERICKA (Freda) JUISTER                       |  | 6 30 1979                          |  | Female                                                              |  | White                                                          |  |
|                                                                                                                                                                                                                                                                                                                   |  | Baltimore, Md.                                   |  | April 7, 1887                      |  | 92                                                                  |  | USA                                                            |  |
|                                                                                                                                                                                                                                                                                                                   |  | BALTIMORE                                        |  | BALTIMORE COUNTY                   |  | Seamstress                                                          |  | Clothes Mfg.                                                   |  |
|                                                                                                                                                                                                                                                                                                                   |  | Md.                                              |  | Middle River                       |  | 1500 Wilson Point Rd. 21220                                         |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                                   |  | Herman Rock                                      |  | Anna Schroeder                     |  |                                                                     |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                                   |  | 218 07 7902                                      |  | Audrey Moser, Daughter             |  | 1318 Wilson Point Rd. Baltimore, Md. 21220                          |  |                                                                |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                              |  |                                                  |  |                                    |  |                                                                     |  |                                                                |  |
| IMMEDIATE CAUSE (a) Cardiovascular arrest                                                                                                                                                                                                                                                                         |  |                                                  |  |                                    |  |                                                                     |  |                                                                |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis                                                                                                                                                                                                                                                                         |  |                                                  |  |                                    |  |                                                                     |  |                                                                |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) U T I                                                                                                                                                                                                                                                                          |  |                                                  |  |                                    |  |                                                                     |  |                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                               |  |                                                  |  |                                    |  |                                                                     |  |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |                                    |  | 20a. AUTOPSY?                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                   |  |                                                  |  |                                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                |  | 21b. TIME OF INJURY                              |  | 21c. HOW INJURY OCCURRED           |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                                   |  | HOUR A.M. MONTH DAY YEAR                         |  |                                    |  |                                                                     |  |                                                                |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY                             |  | 21f. LOCATION                      |  |                                                                     |  |                                                                |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                 |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET                             |  | CITY OR TOWN COUNTY STATE                                           |  |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/15, 19 79, to 6/30, 19 79, that (II) (we) last saw the deceased alive on 6/28, 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                  |  |                                    |  |                                                                     |  |                                                                |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                    |  | DEGREE                                           |  |                                    |  | 22c. DATE SIGNED                                                    |  |                                                                |  |
| N. Haroun, M.D.                                                                                                                                                                                                                                                                                                   |  |                                                  |  |                                    |  | 6/30/79                                                             |  |                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                             |  | 22e. ADDRESS                                     |  |                                    |  |                                                                     |  |                                                                |  |
| NAJJI J HAROUN                                                                                                                                                                                                                                                                                                    |  | 9101 Franklin Square Dr., Balto., MD 21093       |  |                                    |  |                                                                     |  |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                                                                                   |  | 23b. DATE                                        |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION                                                       |  |                                                                |  |
| Burial                                                                                                                                                                                                                                                                                                            |  | 7/3/79                                           |  | Holly Hill Memorial Gardens        |  | Baltimore Co., Md.                                                  |  |                                                                |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR                    |  |                                    |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                                                                |  |
| Bruzdzinski Funeral Home                                                                                                                                                                                                                                                                                          |  | JUL 3 1979                                       |  |                                    |  | P. H. H. H.                                                         |  |                                                                |  |

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1981, 1982, 1983

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7-10-2002 2002

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  |                                                                                                                                                             |                                                                          |                                                                                        |                                                          |                                                                                                                         |                                                                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |  |                                                                                                                                                             |                                                                          |                                                                                        |                                                          |                                                                                                                         |                                                                                              |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FERDINAND EMIL KADAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6 22 79</b>                       |                                                                                        |                                                          |                                                                                                                         |                                                                                              |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  |                                                                                                                                                             | 4 RACE<br><b>White</b>                                                   |                                                                                        | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 21, 1908</b> |                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                    |                                                          |                                                                                                                         |                                                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUPPLY CITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |                                                                                                                                                             |                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Medical Doctor</b> |                                                          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-employed</b>                                                               |                                                                                              |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |  |                                                                                                                                                             | 13b. COUNTY<br><b>Baltimore</b>                                          |                                                                                        | 13c. CITY OR TOWN<br><b>Woodbrook</b>                    |                                                                                                                         | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Emil J. Kadan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Frances Clara Russy</b> |                                                                                        |                                                          |                                                                                                                         |                                                                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><b>220-46-1267</b>                                                                                          |  | 17. INFORMANT ADDRESS<br><b>Mrs. Adelaide H. Kadan-23 Buchanan Rd.</b>                                                                                      |                                                                          |                                                                                        |                                                          |                                                                                                                         |                                                                                              |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>410 -</b> DUE TO, OR AS A CONSEQUENCE OF <b>Coronary atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |                                                                                                                                         |  |                                                                                                                                                             |                                                                          |                                                                                        |                                                          |                                                                                                                         |                                                                                              |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         |  |                                                                                                                                                             |                                                                          |                                                                                        |                                                          |                                                                                                                         |                                                                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |  |                                                                                                                                                             |                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |                                                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                          |                                                                                        |                                                          |                                                                                                                         |                                                                                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                          |                                                                                        |                                                          |                                                                                                                         |                                                                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-22</b> , 19 <b>79</b> , to <b>6-22</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-22</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                 |  |                                                                                                                                         |  |                                                                                                                                                             |                                                                          |                                                                                        |                                                          |                                                                                                                         |                                                                                              |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Leonard G. Hamberry, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         |  | 22c. DATE SIGNED<br><b>6/24/79</b>                                                                                                                          |                                                                          |                                                                                        |                                                          | 22d. ADDRESS<br><b>-21201 Medical Arts Bldg. Balto., Md.</b>                                                            |                                                                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><b>June 25, 1979</b>                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Mausoleum</b>                                                                                             |                                                                          | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                  |                                                          |                                                                                                                         |                                                                                              |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Henry Sander &amp; Sons, Inc., Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>                                                                                                         |                                                                          | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McCreedy</i>                                  |                                                          |                                                                                                                         |                                                                                              |  |

1 3 5 9 1

20 25 30 35

PROOF AND EVIDENCE

BALTIMORE COUNTY

GENCO-101 W. CHARLES ST.

TOWSON

AGENTS INOCENTIAL INVESTIGATION

75

4-22

4-22

4-22

TO

11/1/75

Special Agent in Charge, Baltimore, Maryland

Enclosed for the Baltimore Office are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,  
Special Agent in Charge

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 4. RETAIN PAGE 5 FOR YOUR RECORDS. IF THE DEATH IS SUSPECTED TO BE A BUREAU OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13698

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                                  |                                                     |                                                                                                                                                             |                                                                |                                                                                                 |  |                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES Wilmer. KALKMAN</b>                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                  |                                                     |                                                                                                                                                             |                                                                | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> <b>6 21 19 79</b>                 |  | 2b. HOUR<br><b>3:30 AM</b>                                                          |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 8 21 57</b>                                                                                           | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>57 YRS</b> | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN<br><b>0 0 0 0</b>                                                                                                | 8. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN<br><b>0 0 0 0</b> | 9. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>6/21 19 79</b>                                  |  | 9d. HOUR<br><b>6:10 AM</b>                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                            |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                       |                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                | 1. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto Co</b>                                         |  |                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>PARKVILLE</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)<br><b>2906 Placid Ave</b> |                                                     |                                                                                                                                                             |                                                                | 12. USUAL OCCUPATION (TYPE OF WORK)<br>(IF MOST OF WORKING LIFE)<br><b>Inspector</b>            |  | 13. KIND OF BUSINESS OR INDUSTRY<br><b>Westinghouse</b>                             |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                     | 13b. COUNTY<br><b>Balto</b>                                                                                                                      |                                                     | 13c. CITY OR TOWN<br><b>PARKVILLE</b>                                                                                                                       |                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2906 Placid Ave</b>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wilmer Kalkman</b>                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                                  |                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara Hoefmann</b>                                                                                      |                                                                |                                                                                                 |  |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes Navy</b>                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                  |                                                     | 16b. SOCIAL SECURITY NO.<br><b>220-07-7691</b>                                                                                                              |                                                                | 16c. INFORMANT ADDRESS<br><b>Patricia Kalkman 2906 Placid</b>                                   |  |                                                                                     |  |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292 Arteriosclerotic Cardiovascular Dis</b>                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                  |                                                     |                                                                                                                                                             |                                                                |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |
| IMMEDIATE CAUSE (a):<br>DUE TO, OR AS A CONSEQUENCE OF<br><b>c Arrhythmia</b>                                                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                  |                                                     |                                                                                                                                                             |                                                                |                                                                                                 |  |                                                                                     |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b):<br>DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                  |                                                     |                                                                                                                                                             |                                                                |                                                                                                 |  |                                                                                     |  |
| (c):                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                  |                                                     |                                                                                                                                                             |                                                                |                                                                                                 |  |                                                                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                  |                                                     |                                                                                                                                                             |                                                                |                                                                                                 |  |                                                                                     |  |
| 19a. DATE OF OPERATION<br><b>✓</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                  |                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>✓</b>                                                                                               |                                                                |                                                                                                 |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                  |                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                                |                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |  |                                                                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                  |                                                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                 |                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                     |                                                                                                                                                  |                                                     |                                                                                                                                                             |                                                                |                                                                                                 |  |                                                                                     |  |
| ACTUAL SIGNATURE<br><b>Frank T. Kasik Jr</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                  |                                                     | TITLE (SPECIFY)<br><b>Asst Deputy</b>                                                                                                                       |                                                                | MEDICAL EXAMINER                                                                                |  | DATE SIGNED<br><b>6/21/79</b>                                                       |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>FRANK T. KASIK JR</b>                                                                                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                  |                                                     | ADDRESS<br><b>9605 HARFORD RD</b>                                                                                                                           |                                                                |                                                                                                 |  |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                     |                     | 23b. DATE<br><b>6-23-79</b>                                                                                                                      |                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bel Air Mem. Gardens</b>                                                                                           |                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bel Air HARFORD MD.</b>                        |  |                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Evans Funeral Chapel 8800 HARFORD ROAD</b>                                                                                                                                                                                                                                                                                                                                                             |                     |                                                                                                                                                  |                                                     | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 27 1979</b>                                                                                                         |                                                                | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony J. Brady</b>                                           |  |                                                                                     |  |





BP \_\_\_\_\_  
DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR EXTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                 |  |                                                                                                                                                            |                                                                                                   |                                                                           |                                                                                                                            |                                                             |                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| 1 - FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                 |  |                                                                                                                                                            | 7 9 1 3 6 9 9<br>REG. NO.                                                                         |                                                                           |                                                                                                                            |                                                             |                                                                                                                                      |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Margaret Theresa KARAS                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                 |  |                                                                                                                                                            | 2a DATE OF DEATH MONTH DAY YEAR<br>6 29 79                                                        |                                                                           |                                                                                                                            | 2b HOUR a<br>2:42 m                                         |                                                                                                                                      |
| 3 SEX<br>Fem.                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4 RACE<br>Cau.                                                                                                                  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>8 30 02                                                                                                                  |                                                                                                   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS                                  |                                                                                                                            | 7 IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN. |                                                                                                                                      |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                                                                                                      |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.               |                                                                                                                            |                                                             |                                                                                                                                      |
| 10 CITY OR TOWN OF DEATH<br>Balto.                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hosp. |  |                                                                                                                                                            |                                                                                                   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                           |                                                                                                                                      |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Md. Balto. Balto.                                                                                                                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                                                           | 13e. STREET ADDRESS<br>209 Middleway Rd. Apt. 2B                                                                           |                                                             |                                                                                                                                      |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John I Kammer                                                                                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Genevieve Hildebrandt                                                             |  |                                                                                                                                                            | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>no |                                                                           |                                                                                                                            |                                                             |                                                                                                                                      |
| 16b. SOCIAL SECURITY NO.<br>215-10-1792<br>216-24-7135                                                                                                                                                                                                                                                                                                                                                               |  | 17 INFORMANT<br>Joseph S. Kammer                                                                                                |  |                                                                                                                                                            | ADDRESS<br>Glen Burnie, Md<br>280 Mac Intosh Dr.                                                  |                                                                           |                                                                                                                            |                                                             |                                                                                                                                      |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Bilateral Pulmonary Thrombo-Emboli<br>4151<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                 |  |                                                                                                                                                            |                                                                                                   |                                                                           |                                                                                                                            |                                                             | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  |                                                                                                                                                            | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |                                                                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                             |                                                                                                                                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |                                                                                                   |                                                                           |                                                                                                                            |                                                             |                                                                                                                                      |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                             |                                                                                                   |                                                                           |                                                                                                                            |                                                             |                                                                                                                                      |
| 22a I certify that (I) (this hospital) attended the deceased from 6/22/ 19 79 to 6/29/ 19 79, that (I) (we) last saw the deceased alive on 6/29/ 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                     |  |                                                                                                                                 |  |                                                                                                                                                            |                                                                                                   |                                                                           |                                                                                                                            |                                                             |                                                                                                                                      |
| 22b. SIGNATURE<br>Kai Chow                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |                                                                                                   |                                                                           | 22c. DATE SIGNED<br>6/29/79                                                                                                |                                                             |                                                                                                                                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kai Chow, M.D.                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                 |  | 22e. ADDRESS<br>9000 Franklin Square Drive                                                                                                                 |                                                                                                   |                                                                           |                                                                                                                            |                                                             |                                                                                                                                      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>7-2-79                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Balto. Nat. Cem.                                                                                                     |                                                                                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. Balto. Md.              |                                                                                                                            |                                                             |                                                                                                                                      |
| 24. FUNERAL DIRECTOR NAME<br>John C. Miller Inc.                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                 |  | ADDRESS<br>6415 Belair Rd.                                                                                                                                 |                                                                                                   | 25a. DATE REC'D. BY REGISTRAR 79<br>JUL 2 1979                            |                                                                                                                            |                                                             |                                                                                                                                      |



1 2 3 4 5 6 7 8 9 10 11 12



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                               |  |                                                                     |  | REG. NO. 9 13700                                                                                                                       |  |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                             |  |                                                                     |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                       |  |                                                                                                                         |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>LENA ROSE KATZENELL                                                                                                                                                                                                                                                                                                                          |  |                                                                     |  | JUNE 30, 1979                                                                                                                          |  |                                                                                                                         |  |
| 3. SEX FEMALE                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                     |  | 2b. HOUR A. M. 3:05                                                                                                                    |  |                                                                                                                         |  |
| 4. RACE WHITE                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>OCT. 29, 1901                                                                                       |  |                                                                                                                         |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.                                                                                                                                                                                                                                                                                                                                            |  |                                                                     |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.                                                                             |  |                                                                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAROLINA                                                                                                                                                                                                                                                                                                                              |  |                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY? USA                                                                                                       |  |                                                                                                                         |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                        |  |                                                                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                                                           |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN                                                                                                                                                                                                                                                                                                                                             |  |                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>RANDALLSTOWN NURSING HOME |  |                                                                                                                         |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                                                                                                                                                                                                                                                                                                         |  |                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME                                                                                           |  |                                                                                                                         |  |
| 13a. STATE MARYLAND                                                                                                                                                                                                                                                                                                                                                                |  |                                                                     |  | 13b. CITY OR TOWN RANDALLSTOWN                                                                                                         |  |                                                                                                                         |  |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                  |  |                                                                     |  | 13d. STREET ADDRESS<br>5434 OLD COURT RD. #21133                                                                                       |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>SIMON MILLER                                                                                                                                                                                                                                                                                                                                |  |                                                                     |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SARA CAPLAN                                                                              |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                                                                                                                                                                                                                                                                                                               |  |                                                                     |  | 16b. SOCIAL SECURITY NO. 212-01-6391D                                                                                                  |  |                                                                                                                         |  |
| 17. INFORMANT MRS. SYBIL WHITE                                                                                                                                                                                                                                                                                                                                                     |  |                                                                     |  | 4012 AMY LANE, RANDALLSTOWN, MD 21133                                                                                                  |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute MI</u><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ASCD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>3 yrs</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                     |  |                                                                                                                                        |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                |  |                                                                     |  |                                                                                                                                        |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                         |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                         |  |                                                                                                                         |  |
| 22. I certify that (1) (this hospital) attended the deceased from <u>6/13</u> 19 <u>79</u> to <u>June</u> 19 <u>79</u> , that (1) (we) last saw the deceased alive on <u>6/13</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                            |  |                                                                     |  |                                                                                                                                        |  |                                                                                                                         |  |
| 22a. SIGNATURE<br>H. Gerard Oster / J. Malinow                                                                                                                                                                                                                                                                                                                                     |  |                                                                     |  | 22b. DATE SIGNED<br>6/30/79                                                                                                            |  | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. STANFORD H. MALINOW                                                        |  |
| 22d. ADDRESS<br>3635 OLD COURT RD.                                                                                                                                                                                                                                                                                                                                                 |  |                                                                     |  | 22e. CITY OR TOWN<br>BALTIMORE                                                                                                         |  |                                                                                                                         |  |
| 22f. COUNTY<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                           |  |                                                                     |  | 22g. STATE<br>MARYLAND                                                                                                                 |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>JULY 3, 1979                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW FRIENDSHIP                                                                                |  | 23d. LOCATION<br>BALTIMORE                                                                                              |  |
| 24. FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215                                                                                                                                                                                                                                                                                  |  |                                                                     |  | 25. DATE REC'D. BY REGISTRAR<br>JUL 10 1979                                                                                            |  |                                                                                                                         |  |
| 25a. REGISTRAR'S SIGNATURE<br>Ruthy McBrady                                                                                                                                                                                                                                                                                                                                        |  |                                                                     |  | 25b. REGISTRAR'S SIGNATURE                                                                                                             |  |                                                                                                                         |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                           |                                                                     |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EDGAR KEENE</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 6, 1979</b>          |                                                                                                                                                             |  | 2b. HOUR<br><b>7:45 a.m.</b>                                                                    |  |                                                                                                                            |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 4 RACE<br><b>Black</b>                                                                                                                    |                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 19 01</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SAINT JOSEPH HOSPITAL</b> |                                                                     |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth Steel</b>                                                                     |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                              |                                                                     | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1704 Normal Ave.</b>                                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Keene</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Todd</b> |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-09-0441</b>                                                             |                                                                     | 17. INFORMANT<br>ADDRESS<br><b>Ruth Faulcon 2102 Southern Ave.</b>                                                                                          |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEMIA</b><br><b>5829</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHRONIC GLO MARY RD NAGHATIS?</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                           |                                                                     |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 YRS</b>                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                  |  |                                                                                                                                           |                                                                     |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |                                                                     |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR: A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |                                                                     | 21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED:<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/8/1979</b> to <b>6/6/1979</b> that (I) (we) last saw the deceased alive on <b>6/5/1979</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                          |  |                                                                                                                                           |                                                                     |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Francis T. Daly</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |                                                                     | DEGREE<br><b>MD</b>                                                                                                                                         |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>6/6/79</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Francis T. Daly, M.D.</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |                                                                     | 22e. ADDRESS<br><b>4300 N. Charles St., Apt. 5G, Balto., MD</b>                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>6/11/79</b>                                                                                                               |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Pk.</b>                                                                                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>                         |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |                                                                     | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 8 1979</b>                                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Piering McCreedy</b>                                                                      |  |

BP

10001 2A

RECEIVED  
JUN 10 1971  
FBI - NEW YORK

(M)

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]  
[illegible text follows]

[Large block of illegible text, possibly a memorandum or report body]

DATE: JUN 10 1971  
BY: [illegible]  
[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                     |                                                                                                                               |                                                                                                                                                            |                                                                                | 7 1 3 7 0 2                                                                    |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1 - FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                            |                                                                                | REG. NO.                                                                       |                                                                                                                            |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDWARD KEILBAR JR.                                                                                                                                                                                                                                                                                                                                                |                                                                                                                               |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 12, 1979                           |                                                                                | 2b. HOUR<br>M                                                                                                              |
| 3 SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                            | 4 RACE<br>WHITE                                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>FEB. 6, 1915                                                                                                         | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS                                       |                                                                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                           | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                    |                                                                                |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>62 BURKLEIGH RD. |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MANAGEMENT |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>INSURANCE                                                                             |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                               |                                                                                                                                                            | 13b. CITY OR TOWN<br>BALTIMORE                                                 | 13c. CITY OR TOWN<br>TOWSON                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EDWARD KEILBAR SR.                                                                                                                                                                                                                                                                                                                                             |                                                                                                                               |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>IDA SHECKELLS                 |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES                                                                                                                                                                                                                                                                                                                              |                                                                                                                               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>225-10-3820                                                                                     | 17. INFORMANT<br>ADDRESS<br>ELLEN KEILBAR 62 BURKLEIGH RD. 21204               |                                                                                |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>2500 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertensive Art Cardio Vascular Disease</u> 10 yrs<br>(c) <u>Diabetes Mellitus</u> 3 yrs |                                                                                                                               |                                                                                                                                                            |                                                                                |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 minute                                                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                      |                                                                                                                               |                                                                                                                                                            |                                                                                |                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                 |                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                 |                                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                |                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-14</u> 19 <u>79</u> , to <u>6-12</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5-14</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                             |                                                                                                                               |                                                                                                                                                            |                                                                                |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br><u>Franklin E. Leslie</u>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                               | DEGREE<br><u>MD</u>                                                                                                                                        |                                                                                | 22c. DATE SIGNED                                                               |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Franklin E. Leslie</u>                                                                                                                                                                                                                                                                                                                                       |                                                                                                                               | 22e. ADDRESS<br><u>3501 St Paul St BALTO MD</u>                                                                                                            |                                                                                |                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                               | 23b. DATE<br>JUNE 15, 1979                                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>DULANEY VALLEY                           |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>COCKEYSVILLE BALTO MD                                                        |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MITCHELL-WIEDEFELD HOME 6500 YORK RD.                                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                            | 25a. DATE RECEIVED BY REGISTRAR<br>JUN 18 1979                                 |                                                                                |                                                                                                                            |

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DHMH - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |  |                                                                                  |  | REG. NO. 13703                                                                                  |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME (TYPE OR PRINT)<br>Helen Mary KELBAUGH                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 21, 1979                                                                                                           |  |                                                                                  |  | 2b. HOUR<br>1:00 AM                                                                             |  |                                                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>White                                                                                                                  |  | 5. DATE OF BIRTH<br>Jan. 28, 1901                                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78                                            |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                  |  | IF UNDER 24 HRS<br>HOURS MIN                                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                    |  |                                                                                                 |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>21234                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1808 Wildwood Avenue |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Electronics                                                |  |                                                                                                                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland                                                                                                                                                                                                                                                                     |  |                                                                                                                                   |  | 13b. COUNTY Baltimore                                                                                                                                       |  | 13c. CITY OR TOWN 21234                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1808 Wildwood Avenue                                                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Chenowith                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ann Mary Dei                                                                                               |  |                                                                                  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)<br>No                  |  |                                                                                                                            |  |
| 16b. SOCIAL SECURITY NO.<br>189-07-6633                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                   |  | 17. INFORMANT<br>John G. Kelbaugh                                                                                                                           |  |                                                                                  |  | 17. ADDRESS<br>1808 Wildwood Ave.                                                               |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u><br>4029<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>Hypertensive Cardiovascular Disease</u><br>years<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                  |  |                                                                                                 |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                          |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                  |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                           |  |                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                     |  |                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>9-23-69</u> 19____ to <u>6-21-79</u> 19____, that (I) (we) last saw the deceased alive on <u>5-31-79</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                     |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                  |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>John B. Littleton, MD</u>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |                                                                                  |  | 22c. DATE SIGNED<br>22 June 79                                                                  |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John B. Littleton, MD                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                   |  | 22e. ADDRESS<br>1012 Old North Point Rd. 21224                                                                                                              |  |                                                                                  |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  | 23b. DATE<br>June 23, '79                                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem. Gardens Balto. Co., Md |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |  | ADDRESS<br>8521 Loch Raven Blvd.                                                                                                                            |  |                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 22 1979                                                    |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert Kennedy</u>                                                                        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                    |  |                                                                                                            |                           |                                                                                                                                                             |    |                                                                |    |                    |  |                    |   |                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----|----------------------------------------------------------------|----|--------------------|--|--------------------|---|--------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                            | 7 9 1 3 7 0 4<br>REG. NO. |                                                                                                                                                             |    |                                                                |    |                    |  |                    |   |                                                        |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                            | 2a. DATE OF DEATH         |                                                                                                                                                             |    | MONTH                                                          |    | DAY                |  | YEAR               |   | 2b. HOUR                                               |  |
| Edward N. Kennedy                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                            | June 27                   |                                                                                                                                                             | 19 |                                                                | 79 |                    |  |                    | M |                                                        |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE                                                                                                    |                           | 5. DATE OF BIRTH                                                                                                                                            |    | 6. AGE (IN YEARS LAST BIRTHDAY)                                |    | 7. IF UNDER 1 YEAR |  | 8. IF UNDER 24 HRS |   |                                                        |  |
| MALE                                                                                                                                                                                                                                                                                                                                                                    |  | White                                                                                                      |                           | Nov 12 1904                                                                                                                                                 |    | 74                                                             |    | MONTHS             |  | DAYS               |   | HOURS MIN.                                             |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                               |  | 7c. CITIZEN OF WHAT COUNTRY?                                                                               |                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |    | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |    |                    |  |                    |   |                                                        |  |
| Md                                                                                                                                                                                                                                                                                                                                                                      |  | U. S. A.                                                                                                   |                           |                                                                                                                                                             |    | BALTO                                                          |    |                    |  |                    |   | MD.                                                    |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) |                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |    | 12b. KIND OF BUSINESS OR INDUSTRY                              |    |                    |  |                    |   |                                                        |  |
| CARNEY                                                                                                                                                                                                                                                                                                                                                                  |  | 2715 Second Ave                                                                                            |                           | Main Tenance                                                                                                                                                |    | Schools                                                        |    |                    |  |                    |   |                                                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                 |  |                                                                                                            |                           | 13a. INSIDE CITY LIMITS?                                                                                                                                    |    | 13b. STREET ADDRESS                                            |    |                    |  |                    |   |                                                        |  |
| 13a. STATE 13b. CITY OR TOWN 13c. CITY OR TOWN                                                                                                                                                                                                                                                                                                                          |  |                                                                                                            |                           | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                         |    | 2715 Second Ave                                                |    |                    |  |                    |   |                                                        |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                            |                           | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |    |                                                                |    |                    |  |                    |   |                                                        |  |
| HARRY G. Kennedy                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                            |                           | Emma Deak                                                                                                                                                   |    |                                                                |    |                    |  |                    |   |                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.                                                                                   |                           | 17. INFORMANT                                                                                                                                               |    | ADDRESS                                                        |    |                    |  |                    |   |                                                        |  |
| No                                                                                                                                                                                                                                                                                                                                                                      |  | 213-28-9368                                                                                                |                           | Kathryn V. Kennedy                                                                                                                                          |    | Same                                                           |    |                    |  |                    |   |                                                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Advanced Epidermoid Lung Cancer<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                            |                           |                                                                                                                                                             |    |                                                                |    |                    |  |                    |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                     |  |                                                                                                            |                           |                                                                                                                                                             |    |                                                                |    |                    |  |                    |   |                                                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |                           | 20a. AUTOPSY?                                                                                                                                               |    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |    |                    |  |                    |   |                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                            |                           | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                         |    | YES <input type="checkbox"/> NO <input type="checkbox"/>       |    |                    |  |                    |   |                                                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                 |                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |    |                                                                |    |                    |  |                    |   |                                                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |    |                                                                |    |                    |  |                    |   |                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                            |                           |                                                                                                                                                             |    |                                                                |    |                    |  |                    |   |                                                        |  |
| 22. I certify that (I) (this hospital) attended the deceased from July 10, 1978, to May 22, 1979, that (I) (we) lost<br>saw the deceased alive on May 22, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did not view the body after death.                                                       |  |                                                                                                            |                           |                                                                                                                                                             |    |                                                                |    |                    |  |                    |   |                                                        |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                          |  | DEGREE                                                                                                     |                           | 22c. DATE SIGNED                                                                                                                                            |    |                                                                |    |                    |  |                    |   |                                                        |  |
| Charles A. Padgett                                                                                                                                                                                                                                                                                                                                                      |  | MD                                                                                                         |                           | 6/27/79                                                                                                                                                     |    |                                                                |    |                    |  |                    |   |                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                   |  | 22e. ADDRESS                                                                                               |                           |                                                                                                                                                             |    |                                                                |    |                    |  |                    |   |                                                        |  |
| Charles A. Padgett                                                                                                                                                                                                                                                                                                                                                      |  | 5601 Loch Raven Blvd                                                                                       |                           |                                                                                                                                                             |    |                                                                |    |                    |  |                    |   |                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE                                                                                                  |                           | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |    |                    |  |                    |   |                                                        |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                  |  | 6/30/79                                                                                                    |                           | New Cathedral                                                                                                                                               |    | BALTO MD                                                       |    |                    |  |                    |   |                                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR                                                                              |                           | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |    |                                                                |    |                    |  |                    |   |                                                        |  |
| EVANS FUNERAL Chapel                                                                                                                                                                                                                                                                                                                                                    |  | JUL 2 1979                                                                                                 |                           | Kathryn V. Kennedy                                                                                                                                          |    |                                                                |    |                    |  |                    |   |                                                        |  |

NOV 21 1954

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                      |                          |                                                                                                            |  |                                                                                      |                                                                                                                                                             |                                                                                                  |                                                                   |                                                  |                                   |                                                                                  |  | REG. NO. 13705                                                   |                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------|-----------------------------------|----------------------------------------------------------------------------------|--|------------------------------------------------------------------|--------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>DAE WOO KIM</b>                                                                                                                                                                                                                                                                                                                                                                     |                          |                                                                                                            |  |                                                                                      |                                                                                                                                                             |                                                                                                  |                                                                   |                                                  |                                   |                                                                                  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>June 10 1979</b> | 2b. HOUR<br>130 PM |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br><b>YELLOW</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 7 70</b>                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>8 YRS.</b>                                     | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                               | IF UNDER 24 HRS.<br>HOURS MIN.                                                                   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>JUNE 10 1979</b> |                                                  | 2d. HOUR<br>730 PM                |                                                                                  |  |                                                                  |                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Korea</b>                                                                                                                                                                                                                                                                                                                                                                                    |                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Korea</b>                                                               |  |                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>County</b> MD.         |                                                  |                                   |                                                                                  |  |                                                                  |                    |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                    |                          | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                      |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>                  |                                                                   |                                                  | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                                  |  |                                                                  |                    |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                   |                          |                                                                                                            |  |                                                                                      |                                                                                                                                                             |                                                                                                  |                                                                   |                                                  |                                   |                                                                                  |  |                                                                  |                    |
| 13a. STATE<br><b>md</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |                          | 13b. COUNTY<br><b>Balto</b>                                                                                |  | 13c. CITY OR TOWN                                                                    |                                                                                                                                                             | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |                                                                   | 13e. STREET ADDRESS<br><b>59 SOLAR CIRCLE</b>    |                                   |                                                                                  |  |                                                                  |                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>YONG CHUL KIM</b>                                                                                                                                                                                                                                                                                                                                                                               |                          |                                                                                                            |  |                                                                                      |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bae</b>                                      |                                                                   |                                                  |                                   |                                                                                  |  |                                                                  |                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                           |                          | 16b. SOCIAL SECURITY NO.                                                                                   |  | 17. INFORMANT<br><b>As Above. Mr. Yong Chul Kim</b>                                  |                                                                                                                                                             |                                                                                                  |                                                                   |                                                  |                                   |                                                                                  |  |                                                                  |                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Accidental Death by Drowning</b><br>9108<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost<br>(b) _____<br>(c) _____                                                                                                                                            |                          |                                                                                                            |  |                                                                                      |                                                                                                                                                             |                                                                                                  |                                                                   |                                                  |                                   |                                                                                  |  |                                                                  |                    |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                          |                          |                                                                                                            |  |                                                                                      |                                                                                                                                                             |                                                                                                  |                                                                   |                                                  |                                   |                                                                                  |  |                                                                  |                    |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                    |                                                                                                                                                             |                                                                                                  |                                                                   |                                                  |                                   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                                  |                    |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                          |                          |                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1300 P.M. 6/10 1979</b>        |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Drowning</b> |                                                                   |                                                  |                                   |                                                                                  |  |                                                                  |                    |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                               |                          |                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Loch Raven Dam</b> |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                |                                                                   |                                                  |                                   |                                                                                  |  |                                                                  |                    |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Neglect <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                          |                                                                                                            |  |                                                                                      |                                                                                                                                                             |                                                                                                  |                                                                   |                                                  |                                   |                                                                                  |  |                                                                  |                    |
| ACTUAL SIGNATURE<br><b>Frank T. Kasik Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                |                          |                                                                                                            |  | TITLE (SPECIFY)<br><b>Asst. Dep.</b>                                                 |                                                                                                                                                             | MEDICAL EXAMINER                                                                                 |                                                                   |                                                  | DATE SIGNED<br><b>6/10/79</b>     |                                                                                  |  |                                                                  |                    |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>FRANK T. KASIK JR.</b>                                                                                                                                                                                                                                                                                                                                                                                 |                          |                                                                                                            |  | ADDRESS<br><b>9005 HARFORD RD 21234</b>                                              |                                                                                                                                                             |                                                                                                  |                                                                   |                                                  |                                   |                                                                                  |  |                                                                  |                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                   |                          | 23b. DATE<br><b>June 12, 1979</b>                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>                           |                                                                                                                                                             |                                                                                                  |                                                                   | 23d. LOCATION<br>CITY OR TOWN<br><b>Woodlawn</b> |                                   | COUNTY<br><b>Balto</b>                                                           |  | STATE<br><b>Md.</b>                                              |                    |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G. Truman Schwab</b>                                                                                                                                                                                                                                                                                                                                                                                      |                          |                                                                                                            |  | ADDRESS<br><b>5151 Balto. National Pike</b>                                          |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 15 1979</b>                                              |                                                                   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |                                   |                                                                                  |  |                                                                  |                    |

00101

RECEIVED  
MEDICAL DEPARTMENT  
U.S. ARMY  
HONOLULU, T.H.

DATE: 10-24-41



TO: THE CHIEF, MEDICAL DEPARTMENT  
FROM: [illegible]  
SUBJECT: [illegible]

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FOR  
1- STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13706

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                  |                                        |                                                                                                                                  |  |                                                                    |  |                                                                                                                                                          |                                   |                                                                  |  |                                                                                     |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                  | FIRST MIDDLE LAST<br>Hilda Larkin King |                                                                                                                                  |  | 2b. DATE KNOWN OF DEATH ESTI- MATED                                |  |                                                                                                                                                          | 3. MONTH DAY YEAR<br>June 24 1979 |                                                                  |  | 7b. HOUR<br>11 PM                                                                   |  |  |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br>White |                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-23-03                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                         |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                 |                                   | 7c. DATE PRONOUNCED DEAD                                         |  | 8. MONTH DAY YEAR<br>June 24 1979                                                   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                  |                                        | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |  |                                                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   |                                                                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                  |                                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph's Hospital |  |                                                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary                                                                               |                                   |                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>State                                          |  |  |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                  |                                        | 13b. COUNTY<br>Baltimore                                                                                                         |  | 13c. CITY OR TOWN<br>Baltimore                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                          |                                   | 13e. STREET ADDRESS<br>1301 Ramblewood Rd.                       |  |                                                                                     |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John J. Larkin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                  |                                        |                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anne Gilchrist    |  |                                                                                                                                                          |                                   |                                                                  |  |                                                                                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                  |                                        | 16b. SOCIAL SECURITY NO.<br>212-28-1585                                                                                          |  | 17. INFORMANT ADDRESS<br>Donald V. Coulter 7347 Yorktowne Dr 21204 |  |                                                                                                                                                          |                                   |                                                                  |  |                                                                                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure due to</u><br>8842 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. }<br>(b) <u>Sub Dural Hematoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><u>Generalized ASCHS &amp; Diabetes Mellitus</u> |  |                  |                                        |                                                                                                                                  |  |                                                                    |  |                                                                                                                                                          |                                   |                                                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 Days                             |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                  |                                        |                                                                                                                                  |  |                                                                    |  |                                                                                                                                                          |                                   |                                                                  |  |                                                                                     |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                  |                                        |                                                                                                                                  |  |                                                                    |  |                                                                                                                                                          |                                   |                                                                  |  |                                                                                     |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                  |                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                |  |                                                                    |  |                                                                                                                                                          |                                   |                                                                  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                  |                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>6 P.M. June 12 1979                                                           |  |                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Fell out of Chair in Nursing Home                                       |                                   |                                                                  |  |                                                                                     |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                  |                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Nursing Home                                                      |  |                                                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>513 Stenograph Lane Baltimore MD                                                                    |                                   |                                                                  |  |                                                                                     |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .                                                                                                                              |  |                  |                                        |                                                                                                                                  |  |                                                                    |  |                                                                                                                                                          |                                   |                                                                  |  |                                                                                     |  |  |  |
| ACTUAL SIGNATURE<br>Charles F. O'Donnell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                  |                                        | TITLE (SPECIFY)<br>M.D. Deputy                                                                                                   |  |                                                                    |  | DATE SIGNED<br>6/24/79                                                                                                                                   |                                   |                                                                  |  | MEDICAL EXAMINER                                                                    |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Charles F. O'Donnell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                  |                                        | ADDRESS<br>7501 York Rd. Towson, Md. 21204                                                                                       |  |                                                                    |  |                                                                                                                                                          |                                   |                                                                  |  |                                                                                     |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                  |                                        | 23b. DATE<br>6-27-79                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral                |  |                                                                                                                                                          |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |                                                                                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mitchell-Wiedefeld Home 6500 York Rd. 21212                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                  |                                        |                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 28 1979                       |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                                |                                   |                                                                  |  |                                                                                     |  |  |  |



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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 13707

|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                 |                                                 |                                                                                                                                                             |                       |                                                                                                                                                      |  |                                                                           |  |                                                                                                                               |  |                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>OLGA L. KIRNER                                                                                                                                                                                                                                                                                               |  |                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06 11 79 |                                                                                                                                                             | 2b. HOUR<br>4:15 A.M. |                                                                                                                                                      |  |                                                                           |  |                                                                                                                               |  |                                                 |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>WHITE                                                                                                                |                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 02 04                                                                                                              |                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                                                                                           |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                              |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.                                                                                             |  |                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          |                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                                                                         |  |                                                                           |  |                                                                                                                               |  |                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOUSE IN THE PINES |                                                 |                                                                                                                                                             |                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                         |  |                                                                                                                               |  |                                                 |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |                                                 |                                                                                                                                                             |                       | 13b. COUNTY<br>BALTIMORE                                                                                                                             |  | 13c. CITY OR TOWN<br>LANSDOWNE                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  | 13e. STREET ADDRESS<br>223 FOURTH AVENUE, 21227 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH NEUMANN                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                 |                                                 |                                                                                                                                                             |                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MATILDA GLASER                                                                                      |  |                                                                           |  |                                                                                                                               |  |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                               |  |                                                                                                                                 |                                                 | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-12-2380                                                                                      |                       | 17. INFORMANT<br>ADDRESS<br>AUDREY L. VEASEL, 2701 HAMMONDS FERRY LANE 21227                                                                         |  |                                                                           |  |                                                                                                                               |  |                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Carcinomatosis</u><br><u>1539</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of Colon</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                        |  |                                                                                                                                 |                                                 |                                                                                                                                                             |                       |                                                                                                                                                      |  |                                                                           |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1 1/2 yrs</u><br><u>337</u>                                             |  |                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                      |  |                                                                                                                                 |                                                 |                                                                                                                                                             |                       |                                                                                                                                                      |  |                                                                           |  |                                                                                                                               |  |                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                       |                                                                                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  |                                                                                                                                 |                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                           |  |                                                                                                                               |  |                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                |  |                                                                                                                                 |                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                           |  |                                                                                                                               |  |                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2205-16</u> 19 <u>77</u> to <u>June 11</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>June 9</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (and) (did not) view the body after death. |  |                                                                                                                                 |                                                 |                                                                                                                                                             |                       |                                                                                                                                                      |  |                                                                           |  |                                                                                                                               |  |                                                 |  |
| 22b. SIGNATURE<br><u>Wilmer K. Gallager, Sr. M.D.</u>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |                                                 |                                                                                                                                                             |                       | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>6-12-79</u>                                        |  |                                                                                                                               |  |                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WILMER K. GALLAGER, SR., M.D.                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |                                                 |                                                                                                                                                             |                       | 22e. ADDRESS<br>6209 FREDERICK AVENUE                                                                                                                |  |                                                                           |  |                                                                                                                               |  |                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |                                                 | 23b. DATE<br>06-14-79                                                                                                                                       |                       | 23c. NAME OF CEMETERY OR CREMATORY<br>CREST LAWN GAR. of M. MARRIOTTSTVILLE HOWARD MD.                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                |  |                                                                                                                               |  |                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.                                                                                                                                                                                                                                                                                            |  |                                                                                                                                 |                                                 |                                                                                                                                                             |                       | 24b. ADDRESS<br>21229                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 13 1979                              |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia McCreedy</u>                                                                        |  |                                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 13708

|                                                                                                                                                                                                                                                                                                                                                  |         |                  |                                                                                                           |  |  |                                                                               |  |                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------|-----------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------|--|---------------------------------------------------------------|
| 1. DECEASED NAME<br>(NAME OR PRINT)                                                                                                                                                                                                                                                                                                              |         |                  | 2. DATE OF DEATH                                                                                          |  |  | 3. HOUR                                                                       |  |                                                               |
| Anna Rosalie Kiser                                                                                                                                                                                                                                                                                                                               |         |                  | June 17, 1979                                                                                             |  |  | 11:50 a.m.                                                                    |  |                                                               |
| 4. SEX                                                                                                                                                                                                                                                                                                                                           | 5. RACE | 6. DATE OF BIRTH | 7. AGE (IN YEARS LAST BIRTHDAY)                                                                           |  |  | 8. IF UNDER 1 YEAR                                                            |  |                                                               |
| Female                                                                                                                                                                                                                                                                                                                                           | White   | 12 08 92         | 86 YRS.                                                                                                   |  |  | 6 MONTHS 10 DAYS                                                              |  |                                                               |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                         |         |                  | 10. CITIZEN OF WHAT COUNTRY?                                                                              |  |  | 11. BALTIMORE CITY OR COUNTY OF DEATH                                         |  |                                                               |
| MARYLAND                                                                                                                                                                                                                                                                                                                                         |         |                  | U.S.A.                                                                                                    |  |  | Baltimore County MD.                                                          |  |                                                               |
| 12. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                        |         |                  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  |                                                               |
| CATONSVILLE                                                                                                                                                                                                                                                                                                                                      |         |                  | Frederick Villa Nursing Center                                                                            |  |  | SECRETARY                                                                     |  |                                                               |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                      |         |                  | 16. INSIDE CITY LIMITS?                                                                                   |  |  | 17. STREET ADDRESS                                                            |  |                                                               |
| Maryland                                                                                                                                                                                                                                                                                                                                         |         |                  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                  |  |  | R.R. 1328 W. Lombard Street                                                   |  |                                                               |
| 18. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                |         |                  | 19. MOTHER'S MAIDEN NAME                                                                                  |  |  | 20. ADDRESS                                                                   |  |                                                               |
| AMBROSE                                                                                                                                                                                                                                                                                                                                          |         |                  | KISER                                                                                                     |  |  | ELLICOTT CITY, MD.                                                            |  |                                                               |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                              |         |                  | 22. SOCIAL SECURITY NO.                                                                                   |  |  | 23. INFORMANT                                                                 |  |                                                               |
| NO                                                                                                                                                                                                                                                                                                                                               |         |                  | 220-44-6050                                                                                               |  |  | MARGARET STUTMAN, 3376 N. CHATAM ROAD                                         |  |                                                               |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Inter trochanteric fracture, Right hip U.T.I.</u> |         |                  |                                                                                                           |  |  |                                                                               |  | 25. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH           |
| 4292                                                                                                                                                                                                                                                                                                                                             |         |                  |                                                                                                           |  |  |                                                                               |  | days                                                          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                                    |         |                  |                                                                                                           |  |  |                                                                               |  | years                                                         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.                                                                                                                                                                                                                |         |                  |                                                                                                           |  |  |                                                                               |  |                                                               |
| Inter trochanteric fracture, Right hip U.T.I.                                                                                                                                                                                                                                                                                                    |         |                  |                                                                                                           |  |  |                                                                               |  |                                                               |
| 26. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                            |         |                  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |  |  | 28. AUTOPSY?                                                                  |  | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| 4/18/79                                                                                                                                                                                                                                                                                                                                          |         |                  | Right hip fracture (St. Agnes)                                                                            |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |
| 30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                               |         |                  | 31. TIME OF INJURY                                                                                        |  |  | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |                                                               |
| <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                              |         |                  | 4/18 1979                                                                                                 |  |  | Fell at home, slipped on floor                                                |  |                                                               |
| 33. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                              |         |                  | 34. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  |  | 35. LOCATION                                                                  |  |                                                               |
|                                                                                                                                                                                                                                                                                                                                                  |         |                  | Home                                                                                                      |  |  | 1328 W. Lombard St. Baltimore                                                 |  |                                                               |
| 36. I certify that (I) (this hospital) attended the deceased from June 14, 1979, to June 17, 1979, that (I) (we) last saw the deceased alive on June 14, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |         |                  |                                                                                                           |  |  |                                                                               |  |                                                               |
| 37. SIGNATURE                                                                                                                                                                                                                                                                                                                                    |         |                  | DEGREE                                                                                                    |  |  | 38. DATE SIGNED                                                               |  |                                                               |
| William P. P. M.D.                                                                                                                                                                                                                                                                                                                               |         |                  | M.D.                                                                                                      |  |  | 6/17/79                                                                       |  |                                                               |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                             |         |                  | 40. ADDRESS                                                                                               |  |  | 41. DATE REC'D. BY REGISTRAR                                                  |  |                                                               |
| M. TRABANDER                                                                                                                                                                                                                                                                                                                                     |         |                  | 1891 N. Kething Rd. Woodlawn Md. 21207                                                                    |  |  | JUN 18 1979                                                                   |  |                                                               |
| 42. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                         |         |                  | 43. DATE                                                                                                  |  |  | 44. NAME OF CEMETERY OR CREMATORY                                             |  |                                                               |
| BURIAL                                                                                                                                                                                                                                                                                                                                           |         |                  | 06-20-79                                                                                                  |  |  | LOUDON PARK CEMETERY                                                          |  |                                                               |
| 45. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                        |         |                  | 46. ADDRESS                                                                                               |  |  | 47. BALTIMORE CITY MARYLAND                                                   |  |                                                               |
| HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.                                                                                                                                                                                                                                                                                                    |         |                  | 21229                                                                                                     |  |  | JUN 18 1979                                                                   |  |                                                               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M

(VR A 15 (4)) 9/74

100 / 100



100 / 100

100 / 100

100 / 100

100 / 100

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100 / 100

100 / 100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13709

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

KARL

FIRST

N.M.N

MIDDLE

KLIEM

LAST

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

11 11 85

MONTH

DAY

YEAR

6. AGE (IN YEARS)

93

LAST BIRTHDAY)

YRS.

IF UNDER 1 YR.

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7c. DATE

PRONOUNCED

DEAD

MONTH

DAY

YEAR

2d. HOUR

A.M.

P.M.

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Germany

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

10. CITY OR TOWN OF DEATH

Balto.

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12916 Community Road

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Machinist

12b. KIND OF BUSINESS  
OR INDUSTRY

Plumbing

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

--

13c. CITY OR TOWN

Balto.

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

12916 Community Road

14. FATHER'S NAME

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.

WWII - German

17. INFORMANT

173-10-3277

ADDRESS

18. CAUSE OF DEATH (Enter only one cause, (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐21a. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☒Inquiry ☒

and in my opinion

death resulted from:

Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL  
SIGNATURE

K. S. AHLUWALIA

TITLE (SPECIFY)

M.D.

Deputy

MEDICAL EXAMINER

DATE  
SIGNED

6/30/79

EXAMINER'S NAME  
(TYPE OR PRINT)

K. S. AHLUWALIA

ADDRESS

2112, Dundalk Ave MD 21222

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Removal

23b. DATE

6/30/79

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION  
CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME  
Anatomy BoardADDRESS  
Balto., Md.

25a. DATE REC'D. BY REGISTRAR

JUL 6 1979

25b. REGISTRAR'S SIGNATURE

L. K. M. C. C.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                                |                                                                                                 |                                                   |                                                                                                                               |  | 7 9 1 3 7 1 0 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                         |  | REG. NO.                                                                                                                              |  |                                                                                                                                                             |                                                                                |                                                                                                 |                                                   |                                                                                                                               |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Marion J. KMIOTEK                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 29, 1979                           |                                                                                                 |                                                   | 2b. HOUR<br>7:55P <sub>M</sub>                                                                                                |  |               |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                        |  | 4 RACE<br>White                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>January 30, 1908                                                                                                      |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71<br>YRS                                                    |                                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN.                                                               |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County <sub>MD</sub>                          |                                                   |                                                                                                                               |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bar Keeper |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Mac's Tavern |                                                                                                                               |  |               |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                                                           |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                   | 13e. STREET ADDRESS<br>514 S. Durham Street 21231                                                                             |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Kmiotek                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Julia Sawicka                                                                                              |                                                                                |                                                                                                 |                                                   |                                                                                                                               |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-12-7697                                                                |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Elsie A. Kmiotek, 514 S. Durham St. 21231                                                                                  |                                                                                |                                                                                                 |                                                   |                                                                                                                               |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>410 -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Ventricular arrhythmia and apnea<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                                |                                                                                                 |                                                   |                                                                                                                               |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                  |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                                |                                                                                                 |                                                   |                                                                                                                               |  |               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                |                                                                                                 |                                                   |                                                                                                                               |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                |                                                                                                 |                                                   |                                                                                                                               |  |               |  |
| 22a. I certify that (this hospital) attended the deceased from June 28, 1979, to June 29, 1979, that (we) last saw the deceased alive on June 29, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.                     |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                                |                                                                                                 |                                                   |                                                                                                                               |  |               |  |
| 22b. SIGNATURE<br>Michael Koger MD                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                |                                                                                                 |                                                   | 22c. DATE SIGNED<br>6/29/79                                                                                                   |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael Koger MD                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  | 22e. ADDRESS<br>9000 Franklin Square Dr, 21237                                                                                                              |                                                                                |                                                                                                 |                                                   |                                                                                                                               |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                               |  | 23b. DATE<br>July 3, 1979                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus Cemetery                                                                                               |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |                                                   |                                                                                                                               |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>M.F. Sadowski & Sons, 1808 Eastern Ave. 21231                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                                                                                                                 |                                                                                | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                       |                                                   |                                                                                                                               |  |               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                     |                                                                                                                            |                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| FOR<br>1 - STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                     | 7 9 1 3 7 1 1                                                                                                              |                                                                                  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Philip Knatz</b>                                                                                                                                                                                                                                                                                                             |                                                                                                                                     | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 5 1979</b><br>2b HOUR<br><b>8:00 AM</b>                                      |                                                                                  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                  | 4 RACE<br><b>White</b>                                                                                                              | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 23, 1901</b>                                                                 |                                                                                  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>                                                                                                                                                                                                                                                                                                                           | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                         |                                                                                                                            | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                     |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                            |                                                                                                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                         |                                                                                  |
| 10 CITY OR TOWN OF DEATH<br><b>Upperco</b>                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5505 Emory Road</b> |                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Farmer</b> |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                     | 13a STATE<br><b>Md.</b>                                                                                                    |                                                                                  |
| 13b. COUNTY<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                          | 13c. CITY OR TOWN<br><b>Upperco</b>                                                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            | 13e. STREET ADDRESS<br><b>5505 Emory Road</b>                                    |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward G. Knatz</b>                                                                                                                                                                                                                                                                                                       |                                                                                                                                     | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rebecca Hoffman</b>                                                     |                                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-36-4249</b>                                                       | 17 INFORMANT<br>ADDRESS<br><b>Phyllis Green 121 Alligate Road Owings Mills, Md.</b>                                        |                                                                                  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis - acute</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                                                                                                                     |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hours</b><br><b>years</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                   |                                                                                                                                     |                                                                                                                            |                                                                                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |                                                                                  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                  |                                                                                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                             |                                                                                  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                          |                                                                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1970</b> to <b>June 5, 1979</b> that (I) (we) last saw the deceased alive on <b>June 2, 1979</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                              |                                                                                                                                     |                                                                                                                            |                                                                                  |
| 22b. SIGNATURE<br><b>C. E. McWilliams</b>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                     | 22c. DATE SIGNED<br><b>6-5-79</b>                                                                                          |                                                                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. E. McWilliams M.D.</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                     | 22e. ADDRESS<br><b>11904 Reisterstown Rd Reisterstown Md 21136</b>                                                         |                                                                                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                            | 23b. DATE<br><b>June 8, 1979</b>                                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Memorial Gar., Finksburg, Carroll, Md.</b>                              |                                                                                  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>H. J. Edhardt</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                     | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>                                                                        |                                                                                  |
| ADDRESS<br><b>Owings Mills, Md.</b>                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                     | 25b. REGISTRAR'S SIGNATURE<br><b>H. J. Edhardt</b>                                                                         |                                                                                  |

1 1 1 1 1 1 1



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                              |  |                                                                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                          |  | FIRST<br>WYNN                                                                                                                       |  | MIDDLE<br>ROBERT                                                                                                                                            |  | LAST<br>KOFKEY                                                                                  |  | 7a. DATE KNOWN OF DEATH                                                      |  | 7b. HOUR                                                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>White                                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 24 62                                                                                                              |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>16 YRS.                                                 |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                     |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>6 4 19 79                             |  |
| 7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |                                                                              |  |                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Edgemere                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Point Boat Yard |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student                                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |                                                                              |  |                                                                                     |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br>Baltimore                                                                                                            |  | 13c. CITY OR TOWN<br>Edgemere                                                                                                                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>2418 Sparrows Point Road                              |  |                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William R. Kofskey                                                                                                                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carleen May Harrison                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>216-84-9323                                                         |  | 17. INFORMANT<br>2418 Sparrows Pt. Rd.<br>Walter W. Sievers- Balto. MD 21219 |  |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Submersion and drowning</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                              |  |                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                   |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                              |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR M. MONTH DAY YEAR<br>2130 P.M. 6 4 19 79                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Drowned while swimming                                                     |  |                                                                                                 |  |                                                                              |  |                                                                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Jones's Creek                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>North Point Boat Yard, Bayview Ave. Balto. MD                                                          |  |                                                                                                 |  |                                                                              |  |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> M.D. 21219 |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                              |  |                                                                                     |  |
| ACTUAL SIGNATURE<br>J. Crossan O'Donovan                                                                                                                                                                                                                                                                                                                                                                                                                     |  | TITLE (SPECIFY)<br>Deputy                                                                                                           |  | MEDICAL EXAMINER                                                                                                                                            |  | DATE SIGNED<br>6/4/79                                                                           |  |                                                                              |  |                                                                                     |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>J. CROSSAN O'DONOVAN                                                                                                                                                                                                                                                                                                                                                                                                   |  | ADDRESS<br>2112 DUNDALK AVE., BALTO., MD. 21222                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                              |  |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br>6/7/79                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Carmel Cemetery                                                                                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |                                                                              |  |                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.                                                                                                                                                                                                                                                                                                                                                                                                              |  | ADDRESS<br>7922 Wise Avenue, Dundalk, MD 21222                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 8 1979                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br>Ruthy K. K... ..                                                  |  |                                                                              |  |                                                                                     |  |

BP

S I C I R I





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                              |                                                                        |                                                                                                                                                             |                                                            |                                                                                                                                            |                                            |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROSE KOLOONER</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                              | 2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 3, 1979</b>                   |                                                                                                                                                             |                                                            | 2b. HOUR <b>5:45 A.M.</b>                                                                                                                  |                                            |                                                                                                                            |  |
| 3. SEX <b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE <b>WHITE</b>                                                                         |                                                                        | 5. DATE OF BIRTH <b>SEPT. 13, 1898</b>                                                                                                                      |                                                            | 6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>                                                                                                  |                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                      |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                                                                        |                                            |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>PIKESVILLE</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>MILFORD MANOR NURSING HOME</b> |                                                                        |                                                                                                                                                             |                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR PROFESSION, BY WHOLESALE LIFE)<br><b>HOUSEWIFE</b>                                               |                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                                                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                              |                                                                        |                                                                                                                                                             |                                                            |                                                                                                                                            |                                            |                                                                                                                            |  |
| 13a. STATE <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY <b>BALTO.</b>                                                                    |                                                                        | 13c. CITY OR TOWN <b>BALTIMORE</b>                                                                                                                          |                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            |                                            | 13e. STREET ADDRESS<br><b>7219 PARK HTS. AVE., APT. 102</b><br><b>#21208</b>                                               |  |
| 14. FATHER'S NAME<br><b>ABRAHAM</b> MIDDLE                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                              |                                                                        | 15. MOTHER'S MAIDEN NAME<br><b>REBECCA</b> MIDDLE                                                                                                           |                                                            |                                                                                                                                            |                                            | <b>SUGAR</b>                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-8399</b>                                               |                                                                        | 17. INFORMANT <b>PHILIP F. KOLOONER, JR.</b><br><b>6307 RED CEDAR PLACE</b> <b>#21209</b>                                                                   |                                                            |                                                                                                                                            |                                            |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerotic heart disease &amp; chronic congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>heart failure</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |                                                                                              |                                                                        |                                                                                                                                                             |                                                            |                                                                                                                                            |                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>9 mos</b>                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                                 |  |                                                                                              |                                                                        |                                                                                                                                                             |                                                            |                                                                                                                                            |                                            |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                           |  |                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                            |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                            |                                                                                                                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>9/26</b> , 19 <b>78</b> , to <b>6/3</b> , 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>5/14</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.                                                                                                         |  |                                                                                              |                                                                        |                                                                                                                                                             |                                                            |                                                                                                                                            |                                            |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>H. Ronald Friedman</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                              | DEGREE <b>MD</b>                                                       |                                                                                                                                                             |                                                            | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                            | 22c. DATE SIGNED<br><b>6-3-79</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. Ronald Friedman, MD</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                              | 22e. ADDRESS<br><b>6715 Park Heights Ave.</b>                          |                                                                                                                                                             |                                                            |                                                                                                                                            |                                            |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                              | 23b. DATE<br><b>JUNE 4, 1979</b>                                       |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SHAAAREI ZION</b> |                                                                                                                                            | 23d. LOCATION<br><b>ROSEDALE BALTO. MD</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                              |                                                                        |                                                                                                                                                             |                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 6 1979</b>                                                                                         |                                            | 25b. REGISTRAR'S SIGNATURE<br><b>Pietro M. Brady</b>                                                                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



13110

June 21/94 5:30

RECEIVED

RECEIVED

TO THE  
HONORABLE  
MEMBERS OF THE  
LEGISLATIVE COUNCIL  
OF THE  
PROVINCE OF ONTARIO  
IN  
PARLIAMENT ASSEMBLED  
AT  
TORONTO  
ON  
JUNE 21/94

Presented by  
HON. J. H. MUNRO  
MINISTER OF AGRICULTURE  
AND  
AGRICULTURAL COLONIZATION

REPORT  
ON  
THE  
PROGRESS OF THE  
AGRICULTURAL COLONIZATION  
DEPARTMENT  
DURING THE  
YEAR  
1893-94

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13714

1. FOR  
STATE  
REGISTRAR1 DECEASED NAME  
(TYPE OR PRINT)

ALFRED

J.

KONE

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

6

-17

-79

10:55A

3 SEX

MALE

4 RACE

CAUC.

5. DATE OF BIRTH

10/31/01

6 AGE (IN YEARS LAST BIRTHDAY)

78

IF UNDER 1 YEAR

IF UNDER 72 HRS

MONTHS

DAYS

HOURS

MIN.

YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MD.

7b. CITIZEN OF WHAT COUNTRY?

U.S.

8. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9 BALTIMORE CITY OR COUNTY OF DEATH

BALTO. COUNTY

MD.

10 CITY OR TOWN OF DEATH

TOWSON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

GREATER BALTO. MEDICAL CENTER

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

CHAUFFEUR

12b. KIND OF BUSINESS OR INDUSTRY

RETIRED.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD.

13b. COUNTY

BALTO.

13c. CITY OR TOWN

BALTO.

13d. INSIDE CITY LIMITS?

YES

NO

13e. STREET ADDRESS

LOT WYMANOKE AVE.

14. FATHER'S NAME

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO

216-09-0591

17. INFORMANT

PEARL KONE

ADDRESS

SAME

18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARREST

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

ACUTE URINARY RETENTION MALNUTRITION, DEHYDRATION AND HEPATIC INSUFFICIENCY, RT. SIDED KLEBSIELLA AND PROTEUS PNEUMONIA

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES

NO

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES

NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 6/4 19 79, 6/17 19 79, that (I) (we) lost saw the deceased alive on 6/17 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

DR. PARAMJIT K. JOSHI

22e. ADDRESS

GREATER BALTO. MEDICAL CENTER  
6701 N. CHARLES STREET, TOWSON, 21204

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

6/20/79

23c. NAME OF CEMETERY OR CREMATORY

LORRAINE PK.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

BALTO. MD.

24. FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JUN 19 1979

Rickey McCready

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11/11/11

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11/11/11

BY SP-5 J. K. JONES

RE: [REDACTED] (S) [REDACTED]  
[REDACTED] (S) [REDACTED]  
[REDACTED] (S) [REDACTED]

11/11/11

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 11/11/11 BY SP-5 J. K. JONES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                |                                                                                                                                                               |  |                                                                                              |  |                                                                                                                         |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELENA</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    | 2a. DATE OF DEATH MONTH DAY YEAR <b>6-3-79</b> |                                                                                                                                                               |  | 2b. HOUR <b>1030</b> P.M.                                                                    |  |                                                                                                                         |                                              |
| 3. SEX <b>female</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE <b>W</b>                                                                                                                   |                                                | 5. DATE OF BIRTH MONTH DAY YEAR <b>04 17 93</b>                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                        |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                         |                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.                                    |  |                                                                                                                         |                                              |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MAJOR CARE ROSSVILLE</b> |                                                |                                                                                                                                                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOME MAKER</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| 13a. STATE <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY                                                                                                                        |                                                | 13c. CITY OR TOWN <b>BALTIMORE</b>                                                                                                                            |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>2700 DILLON ST.</b>                                                                              |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH WISNIEWSKI</b>                                                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>                                                                          |                                                |                                                                                                                                                               |  |                                                                                              |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO. <b>214-12-1839</b>                                                                                        |                                                | 17. INFORMANT ADDRESS <b>GERARD KORDONSKI 3424 DUNHAVEN RD</b>                                                                                                |  |                                                                                              |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>- Acute Myocardial infarction</b><br>2859 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>- Arteriosclerotic cardiovascular disease</b><br>(c) <b>- Anemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                    |                                                |                                                                                                                                                               |  |                                                                                              |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)<br><b>Senile Dementia</b>                                                                                                                                                                                                                                  |  |                                                                                                                                    |                                                |                                                                                                                                                               |  |                                                                                              |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |                                                |                                                                                                                                                               |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12/21/1979</b>                                                                     |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                |  |                                                                                              |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |                                                | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                |  |                                                                                              |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/21/1979</b> to <b>6/3/1979</b> , that (we) last saw the deceased alive on <b>10:20pm 6/3/1979</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (we) (did) <del>not</del> view the body after death.                                  |  |                                                                                                                                    |                                                |                                                                                                                                                               |  |                                                                                              |  |                                                                                                                         |                                              |
| 22b. SIGNATURE <b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |                                                | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                              |  | 22c. DATE SIGNED <b>6/4/79.</b>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. M. TUN</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                                | 22e. ADDRESS <b>2110 Pot Spring Road Md 21093.</b>                                                                                                            |  |                                                                                              |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE <b>6/8/79</b>                                                                                                            |                                                | 23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY</b>                                                                                                         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>                                  |  |                                                                                                                         |                                              |
| 24. FUNERAL DIRECTOR NAME <b>RAYMOND L. KACZOROWSKI</b> ADDRESS <b>2525 FLEET ST.</b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |                                                | 25. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                                |  |                                                                                                                         |                                              |

BP

01101 11

*[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side. The text is mostly mirrored and difficult to decipher.]*



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13716

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                 |                                                        |                                                                                                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>REGINA M. KOZLOWSKI</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>06 01 79</b> |                                                                                                                                                                |                                                                           | 2b. HOUR<br><b>7:18PM</b>                                                                       |                                                                                                                            |                                                                                                      |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>Caucasian</b>                                                                                                                     |                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 25, 1925</b>                                                                                                      |                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><b>54</b> YRS.                     |                                                                                                                            | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS.                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                   |                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TOWSON</b> <i>Baltimore Co.</i> MD                   |                                                                                                                            |                                                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N. CHARLES STREET</b> |                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cashier</b>                                                                             |                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>                                         |                                                                                                                            |                                                                                                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                        |  | 13b. COUNTY<br><b>-</b>                                                                                                                         |                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                          |                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>3237 Kentucky Avenue</b>                                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Golembieski</b>                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna -</b>                                                                                  |                                                        |                                                                                                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                    |  | 16b. (IF YES, GIVE WAR OR DATES)<br><b>-</b>                                                                                                    |                                                        | 17. INFORMANT<br>ADDRESS<br><b>Adam L. Kozlowski (husb) same as 13</b>                                                                                         |                                                                           |                                                                                                 |                                                                                                                            |                                                                                                      |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br><b>1990</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>DISSEMINATED CARCINOMA</b><br>(c) <b>UNKNOWN PRIMARY</b>                           |  |                                                                                                                                                 |                                                        |                                                                                                                                                                |                                                                           |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 HOURS</b><br><b>2 MONTHS</b><br><b>UNKNOWN</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):                                                                                                                                                                                                                                 |  |                                                                                                                                                 |                                                        |                                                                                                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                                                                                      |  |
| 19a. DATE OF OPERATION<br><b>1958</b>                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NOT KNOWN</b>                                                                            |                                                        |                                                                                                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                               |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                 |                                                                           |                                                                                                 |                                                                                                                            |                                                                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                           |                                                                                                 |                                                                                                                            |                                                                                                      |  |
| 22a. I certify that (I) (this hospital attended the deceased from <b>05/05</b> , 19 <b>79</b> , to <b>06/01</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>06/01</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                 |                                                        |                                                                                                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                                                                                      |  |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                 |                                                        | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                           |                                                                                                 |                                                                                                                            | 22c. DATE SIGNED<br><b>6-1-79</b>                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. F.V. MC L BOOTH</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |                                                        | 22e. ADDRESS<br><b>GREATER BALTIMORE MEDICAL CENTER</b>                                                                                                        |                                                                           |                                                                                                 |                                                                                                                            |                                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br><b>6/6/79</b>                                                                                                                      |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cem.</b>                                                                                               |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |                                                                                                                            |                                                                                                      |  |
| 24. FUNERAL HOME<br><b>Schumacher Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                             |  | 25. ADDRESS<br><b>3331 Brehms Lane Balto. Md. 21213</b>                                                                                         |                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1979</b>                                                                                                             |                                                                           | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                |                                                                                                                            |                                                                                                      |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

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802477

28-10-10

2017-2018

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                        |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                                            |  |                                                     |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                |  | 79 13717<br>REG. NO.                                                                                                                |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                                            |  |                                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                         |  | FIRST<br>MARY                                                                                                                       |  | MIDDLE<br>A.                                                                                                                                                |  | LAST<br>KRAUS                                                                  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 21, 1979                                                                          |  | 7b. HOUR<br>11:15 <sup>M</sup>                      |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>Caucasian                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 4, 1892                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86<br>YRS                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  | IF UNDER 24 HRS<br>HOURS MIN.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD                   |  |                                                                                                                            |  |                                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Garrison                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Garrison Valley Center |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Church Hosp                                                                           |  |                                                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                     |  | 13a. STATE<br>Maryland                                                                                                              |  | 13b. COUNTY<br>Baltimore                                                                                                                                    |  | 13c. CITY OR TOWN<br>Brooklyn                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>3618 St. Victor Street 21225 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Krelovec                                                                                                                                                                                                                                                                   |  |                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine - -                                                                                              |  |                                                                                |  |                                                                                                                            |  |                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-                                                                        |  | 17. INFORMANT<br>Charles J. Kraus                                                                                                                           |  | ADDRESS<br>5302 Carter Avenue 21214                                            |  |                                                                                                                            |  |                                                     |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASCVD<br>7159 DUE TO, OR AS A CONSEQUENCE OF MI<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Degenerative Osteoarthritis<br>(c) YRS |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>YRS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)<br>Chronic cholecystitis & cholelithiasis                                                                                                                                               |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                                            |  |                                                     |  |
| 19a. DATE OF OPERATION<br>7/23/79                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Sigmoidectomy & colon                                                           |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                |  |                                                                                                                            |  |                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                |  |                                                                                                                            |  |                                                     |  |
| 22a. I certify that (1) this hospital attended the deceased from 6/19, 1979, to 6/21, 1979, and that (2) (we) lost saw the deceased alive on 6/21, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.            |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                                            |  |                                                     |  |
| 22b. SIGNATURE<br>Lawrence Boas                                                                                                                                                                                                                                                                                             |  | DEGREE<br>M.D.                                                                                                                      |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |                                                                                |  | 22c. DATE SIGNED<br>6/21/79                                                                                                |  |                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Lawrence Boas, M.D.                                                                                                                                                                                                                                                            |  |                                                                                                                                     |  | 22e. ADDRESS<br>50 Scot Adam Road, Cockeysville                                                                                                             |  |                                                                                |  |                                                                                                                            |  |                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                         |  | 23b. DATE<br>6/25/79                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery                                                                                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Baltimore, Md.                         |  |                                                                                                                            |  |                                                     |  |
| 24. FUNERAL DIRECTOR'S NAME<br>Stummack Funeral Home, Inc.                                                                                                                                                                                                                                                                  |  | ADDRESS<br>3331 Brehms Lane Balto. Md. 21213                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 26 1979                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>Patricia Kelly                                   |  |                                                                                                                            |  |                                                     |  |

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U.S. DEPT. OF JUSTICE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                 |                                                                                                                                                             |                                                                                      |                                                                                        |                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MILDRED B. KRONTHAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                 |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH <b>06</b> DAY <b>30</b> YEAR <b>79</b>                    |                                                                                        | 2b. HOUR<br><b>4 A</b> M                                                                        |
| 3. SEX<br><b>F</b> EMALE                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br><b>C</b> AUCASIAN                                                                                                                    | 5. DATE OF BIRTH<br>MONTH <b>04</b> DAY <b>30</b> YEAR <b>98</b>                                                                                            |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                      |                                                                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b> MD.                       |                                                                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6800 LIBERTY RD., APT. 1004</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |                                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                             |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                 |                                                                                                                                                             | 13b. COUNTY<br><b>BALTO</b>                                                          | 13c. CITY OR TOWN<br><b>BALTO.</b>                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST <b>JACOB</b> MIDDLE LAST <b>BARRON</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                 |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>DORA</b> MIDDLE LAST <b>KUSHNER</b>             |                                                                                        |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br><b>213-34-5889</b>                                                                                                              |                                                                                      | 17. INFORMANT<br><b>HYMAN J. KRONTHAL</b><br><b>6800 LIBERTY RD., APT. 1004</b> #21207 |                                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CANCER</b><br><b>1539</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CA of colon with widespread metastasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>metastasis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 months</b> |                                                                                                                                                 |                                                                                                                                                             |                                                                                      |                                                                                        |                                                                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                 |                                                                                                                                                             |                                                                                      |                                                                                        |                                                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                                                                                 |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                 |                                                                                                                                                             |                                                                                      |                                                                                        |                                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)         |                                                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |                                                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)                                                                                                                                                            |                                                                                                                                                 |                                                                                                                                                             |                                                                                      |                                                                                        |                                                                                                 |
| 22b. SIGNATURE<br><b>Peter Broszlan, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                 | DEGREE                                                                                                                                                      |                                                                                      | 22c. DATE SIGNED<br><b>6-30-79</b>                                                     |                                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER BROSLAN, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                 | 22e. ADDRESS<br><b>600 REISTERSTOWN, 21208</b>                                                                                                              |                                                                                      |                                                                                        |                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                 | 23b. DATE<br><b>JULY 1, 1979</b>                                                                                                                            |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HAR ZION TIFERETH ISRAEL</b>                  |                                                                                                 |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                 |                                                                                                                                                             |                                                                                      |                                                                                        |                                                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                 |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 3 1979</b>                                   |                                                                                        | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey R. Brady</b>                                           |

MEDICAL CERTIFICATION

2 9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                              |  |                                                                      |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|--|----------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                            |  | REG. NO. 13719                                                       |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                   |  | FIRST                                                                |  | MIDDLE                                                                        |  | LAST                                                                                                                            |  | 2a DATE OF DEATH MONTH DAY YEAR                                                                        |  | 2b HOUR                                                      |  |                                  |  |
| CLIFFORD                                                                                                                                                                                                                                                                                                          |  | J.                                                                   |  |                                                                               |  | KROSKI Sr.                                                                                                                      |  | 06 22 79                                                                                               |  | 9:30P M                                                      |  |                                  |  |
| 3 SEX                                                                                                                                                                                                                                                                                                             |  | 4 RACE                                                               |  | 5 DATE OF BIRTH                                                               |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                                                  |  | 7a BIRTHPLACE (STATE OR FOREIGN)                                                                       |  | 7b CITIZEN OF WHAT COUNTRY?                                  |  |                                  |  |
| Male                                                                                                                                                                                                                                                                                                              |  | White                                                                |  | Dec. 25, 1929                                                                 |  | 49                                                                                                                              |  | Baltimore                                                                                              |  | U.S.A.                                                       |  |                                  |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                                                                                                                                                                                              |  | 9 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                           |  | 10 CITY OR TOWN OF DEATH                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b KIND OF BUSINESS OR INDUSTRY |  |
|                                                                                                                                                                                                                                                                                                                   |  |                                                                      |  | TOWSON                                                                        |  | BALTIMORE                                                                                                                       |  | GBMC 6701 N. CHARLES STREET                                                                            |  | Supt. Auto Terminal                                          |  | Conrail                          |  |
| 13a STATE                                                                                                                                                                                                                                                                                                         |  | 13b COUNTY                                                           |  | 13c CITY OR TOWN                                                              |  | 13d INSIDE CITY LIMITS?                                                                                                         |  | 13e STREET ADDRESS                                                                                     |  | 14 FATHER'S NAME                                             |  | 15 MOTHER'S MAIDEN NAME          |  |
| Maryland                                                                                                                                                                                                                                                                                                          |  | Baltimore                                                            |  | Baltimore                                                                     |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 333 S. Chester Street                                                                                  |  | James                                                        |  | Marie Stayjewski                 |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                  |  | 16b SOCIAL SECURITY NO.                                              |  | 17 INFORMANT                                                                  |  | 18 ADDRESS                                                                                                                      |  | 19                                                                                                     |  | 20                                                           |  | 21                               |  |
| No                                                                                                                                                                                                                                                                                                                |  | none                                                                 |  | Mrs. Rosalie Kroski                                                           |  | 333 S. Chester Street                                                                                                           |  |                                                                                                        |  |                                                              |  |                                  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                           |  |                                                                      |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |  |                                  |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                      |  |                                                                      |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| IMMEDIATE CAUSE (a) CARCINOMA OF BLADDER                                                                                                                                                                                                                                                                          |  |                                                                      |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| 1889                                                                                                                                                                                                                                                                                                              |  |                                                                      |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                    |  |                                                                      |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                    |  |                                                                      |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                    |  |                                                                      |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| (c)                                                                                                                                                                                                                                                                                                               |  |                                                                      |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                |  |                                                                      |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                             |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |                                                                               |  | 20a AUTOPSY?                                                                                                                    |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                          |  |                                                              |  |                                  |  |
|                                                                                                                                                                                                                                                                                                                   |  |                                                                      |  |                                                                               |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                               |  |                                                              |  |                                  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                 |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR                          |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
|                                                                                                                                                                                                                                                                                                                   |  | P.M. 19                                                              |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                             |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION STREET                                                           |  | CITY OR TOWN                                                                                                                    |  | COUNTY                                                                                                 |  | STATE                                                        |  |                                  |  |
|                                                                                                                                                                                                                                                                                                                   |  |                                                                      |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 06/01 19 79, to 06/22 19 79, that (I) (we) lost saw the deceased alive on 06/22 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                      |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| 22b SIGNATURE                                                                                                                                                                                                                                                                                                     |  | DEGREE                                                               |  |                                                                               |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED                                                                                        |  |                                                              |  |                                  |  |
|                                                                                                                                                                                                                                                                                                                   |  |                                                                      |  |                                                                               |  |                                                                                                                                 |  | 06/22/79                                                                                               |  |                                                              |  |                                  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                              |  | 22e ADDRESS                                                          |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| DR. S.O. GIRDHAR                                                                                                                                                                                                                                                                                                  |  | GREATER BALTIMORE MEDICAL CENTER                                     |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                          |  | 23b DATE                                                             |  | 23c NAME OF CEMETERY OR CREMATORY                                             |  | 23d LOCATION CITY OR TOWN                                                                                                       |  | COUNTY                                                                                                 |  | STATE                                                        |  |                                  |  |
| Burial                                                                                                                                                                                                                                                                                                            |  | 6-26-1979                                                            |  | Holy Rosary                                                                   |  | Baltimore                                                                                                                       |  | Baltimore County                                                                                       |  | Maryland                                                     |  |                                  |  |
| 24 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                               |  | 25a DATE REC'D BY REGISTRAR                                          |  |                                                                               |  | 25b DATE OF DEATH                                                                                                               |  | 25c SIGNATURE                                                                                          |  |                                                              |  |                                  |  |
| Lilly & Zeiler Inc. 1901-07 Eastern Avenue                                                                                                                                                                                                                                                                        |  | JUN 25 1979                                                          |  |                                                                               |  |                                                                                                                                 |  |                                                                                                        |  |                                                              |  |                                  |  |



*[Handwritten signature]*

JUN 2 1972



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13720  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                           |  |                                                                                                                                                           |  |                                                                                              |  |                                                                                                                |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|-------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------|-----------------------------------|------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 6 7 19 79                                       |  |                                                                                                                                                           |  |                                                                                              |  |                                                                                                                |  |                                                    |  | 2b. HOUR M 10:10                                                  |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                         |  | 3. SEX Male                                                                                                               |  |                                                                                                                                                           |  |                                                                                              |  |                                                                                                                |  |                                                    |  | 4. RACE White                                                     | 5. DATE OF BIRTH MONTH DAY YEAR 1/19/63 | 6. AGE (IN YEARS LAST BIRTHDAY) 16 YRS.                                                    | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 9. DATE PRONOUNCED DEAD 6 7 19 79 | 10. HOUR M 10:10 |  |
| 11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. CITIZEN OF WHAT COUNTRY? USA                                                                                          |  | 13. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 14. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.                                  |  |                                                                                                                |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| 15. CITY OR TOWN OF DEATH Essex                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 558 Wellbrook Rd. |  |                                                                                                                                                           |  |                                                                                              |  |                                                                                                                |  |                                                    |  | 17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE |                                         | 18. KIND OF BUSINESS OR INDUSTRY                                                           |                                          |                                            |                                   |                  |  |
| 19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY BALTO                                                                                                         |  | 13c. CITY OR TOWN ESSEX                                                                                                                                   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS 457 TOWNER RD                                                                              |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT F. KRUEGER                                                                                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE BYRAN                                                                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO                                                                                     |  | 16b. SOCIAL SECURITY NO. UNK                                                                 |  | 17. INFORMANT ADDRESS ROBERT F. KRUEGER ABOVE                                                                  |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                           |  |                                                                                                                                                           |  |                                                                                              |  |                                                                                                                |  |                                                    |  |                                                                   |                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                               |                                          |                                            |                                   |                  |  |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound back of head (rifle)                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                           |  |                                                                                                                                                           |  |                                                                                              |  |                                                                                                                |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                           |  |                                                                                                                                                           |  |                                                                                              |  |                                                                                                                |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                           |  |                                                                                                                                                           |  |                                                                                              |  |                                                                                                                |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                           |  |                                                                                                                                                           |  |                                                                                              |  |                                                                                                                |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |  |                                                                                                                           |  |                                                                                                                                                           |  |                                                                                              |  |                                                                                                                |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                         |  |                                                                                              |  |                                                                                                                |  |                                                    |  |                                                                   |                                         | 20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                          |                                            |                                   |                  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                           |  |                                                                                                                           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:30xx 6 7 19 79                                                                                             |  |                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Gun discharged while being moved |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                               |  |                                                                                                                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house                                                                                         |  |                                                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 558 Wellbrook Rd. Essex Balto. MD                               |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                                                                                                           |  |                                                                                                                                                           |  |                                                                                              |  |                                                                                                                |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| ACTUAL SIGNATURE Virginia L. Dolan MD                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                           |  | M.D. Assistant                                                                                                                                            |  |                                                                                              |  | DATE SIGNED 6/7/79                                                                                             |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                           |  | ADDRESS 111 Penn St. Balto., MD.                                                                                                                          |  |                                                                                              |  |                                                                                                                |  |                                                    |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                           |  | 23b. DATE 6/11/79                                                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY OAK LAWN                                                  |  |                                                                                                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. |  |                                                                   |                                         |                                                                                            |                                          |                                            |                                   |                  |  |
| 24. FUNERAL DIRECTOR NAME J. G. CONNELLY                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                           |  | ADDRESS 300 MACE                                                                                                                                          |  |                                                                                              |  | 25a. DATE RECEIVED BY REGISTRAR JUN 11 1979                                                                    |  |                                                    |  | REGISTRAR'S SIGNATURE [Signature]                                 |                                         |                                                                                            |                                          |                                            |                                   |                  |  |



05131 1A



UNIT 1813

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |  | 7 1 3 7 2 1                                                                                                                                              |  |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |  | REG. NO.                                                                                                                                                 |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>EDYTHE N. KUHN</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6/9/79</b>                                                                                                        |  | 2b. HOUR<br><b>5 AM</b>                                                                                                 |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>WHITE</b>                                                                                                          |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>NOV. 25, 1897</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>81</b>                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA.</b>                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CO.</b> MD.                                                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. CO.</b>                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MULTI-MED. N.H.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b> 13b. COUNTY<br><b>BALTO.</b> 13c. CITY OR TOWN                                                                                                                                                                                               |  |                                                                                                                                  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS<br><b>218 CHURCH LA. 21208</b>          |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>CHARLES A. MYERS</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>BEATHA V. HARTENS</b>                                                                                   |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>—</b>                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><b>308-12-2027</b>                                                                                   |  | 17. INFORMANT ADDRESS<br><b>TEROME SKRZYPIEC 148 SIPPLE AVE. 21236</b>                                                                                   |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Unresolving pneumonia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Cerebrovascular dis.</b>                                                                                                                                                                                               |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/22</b> , 19 <b>79</b> , to <b>6/9</b> , 19 <b>79</b> , that (II) (we) last saw the deceased alive on <b>6/7</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) did (did not) view the body after death. |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><b>N. Haroun, M.D.</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                  |  | DEGREE<br><b>M.D.</b>                                                                                                                                    |  | 22c. DATE SIGNED<br><b>6/9/79</b>                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NAVI JOSEPH HAROUN</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  |  | 22e. ADDRESS<br><b>9101 Franklin Square Dr., BALTO. 21237</b>                                                                                            |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><b>6-12-79</b>                                                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DRUID-RIDGE</b>                                                                                                 |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO CO. MD</b>                                                          |  |
| 24. FUNERAL DIRECTOR NAME<br><b>NEWELL F.H. Pikesville MD.</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>Dorothy McCready</b>                                                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 13722

|                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |                                                |                                                                                                                                                             |                                                                                |                                                                                                                            |                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Gladys S. Laferty                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6/25/79 |                                                                                                                                                             | 2b. HOUR<br>8:40A M                                                            |                                                                                                                            |                                               |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>White                                                                                                                             |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 19, 1901                                                                                                        |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                    |                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                       |                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                                              |                                               |  |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC, 6701 N. Charles St. 21204 |                                                |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |                                                |                                                                                                                                                             |                                                                                |                                                                                                                            |                                               |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br>Baltimore                                                                                                                     |                                                | 13c. CITY OR TOWN<br>Lutherville                                                                                                                            |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William A. Sailer                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Gertrude Kirkpatrick                                                                                       |                                                                                |                                                                                                                            |                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>220-44-5280                                                                                                      |                                                | 17. INFORMANT<br>ADDRESS<br>John E. Laferty Lutherville, Maryland                                                                                           |                                                                                |                                                                                                                            |                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic Obstruction Pulmonary Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>Pneumonia</u> |  |                                                                                                                                              |                                                |                                                                                                                                                             |                                                                                |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                       |  |                                                                                                                                              |                                                |                                                                                                                                                             |                                                                                |                                                                                                                            |                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                             |                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                                                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                   |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                |                                                                                                                            |                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                       |                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                |                                                                                                                            |                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/19/79</u> , 19____, to <u>6/25/79</u> , 19____, that (I) (we) last saw the deceased alive on <u>6/25/79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |                                                                                                                                              |                                                |                                                                                                                                                             |                                                                                |                                                                                                                            |                                               |  |
| 22b. SIGNATURE<br><u>Stephen Laiken M.D.</u>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |                                                | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                | 22c. DATE SIGNED<br>6/25/79                                                                                                |                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stephen Laiken, M.D.                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |                                                | 22e. ADDRESS<br>GBMC, 6701 N. Charles St. 21204                                                                                                             |                                                                                |                                                                                                                            |                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br>June 28, 1979                                                                                                                   |                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cem.                                                                                                   |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville, Balto., Md.                                                    |                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ruck Towson Funeral Home, Inc. Towson, Maryland                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |                                                | 25a. DATE REC'D. BY REGISTRAR<br>JUN 26 1979                                                                                                                |                                                                                | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                           |                                               |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                |         |                                                                                                            |  |                                                                                       |  |                                                                     |  |                                                 |  |                                              |  |        |  |      |  |          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-------------------------------------------------|--|----------------------------------------------|--|--------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                            |         | FIRST                                                                                                      |  | MIDDLE                                                                                |  | LAST                                                                |  | 2b. DATE KNOWN<br>OF DEATH                      |  | MONTH                                        |  | DAY    |  | YEAR |  | 2c. HOUR |  |
| Robert                                                                                                                                                         |         | R.                                                                                                         |  | Landon                                                                                |  |                                                                     |  | 6-2-79                                          |  | 19                                           |  | 79     |  | 3    |  | A        |  |
| 3. SEX                                                                                                                                                         | 4. RACE | 5. DATE OF BIRTH                                                                                           |  | 6. AGE (IN YEARS)                                                                     |  | IF UNDER 1 YR.                                                      |  | IF UNDER 24 HRS.                                |  | 7c. DATE<br>PRONOUNCED<br>DEAD               |  | MONTH  |  | DAY  |  | YEAR     |  |
| Male                                                                                                                                                           | White   | July 4, 1920                                                                                               |  | 58                                                                                    |  | YRS.                                                                |  |                                                 |  | 19                                           |  |        |  |      |  | M        |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                   |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH            |  |                                              |  |        |  |      |  | MD       |  |
| Maryland                                                                                                                                                       |         | U.S.A.                                                                                                     |  |                                                                                       |  |                                                                     |  | Baltimore County,                               |  |                                              |  |        |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                      |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                      |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |                                                 |  |                                              |  |        |  |      |  |          |  |
| Catonsville                                                                                                                                                    |         | 1210 Westerlee Place Apt. 1-D                                                                              |  | Building Supervisor                                                                   |  | Kewick                                                              |  |                                                 |  |                                              |  |        |  |      |  |          |  |
| 13a. STATE                                                                                                                                                     |         | 13b. CITY                                                                                                  |  | 13c. CITY OR TOWN                                                                     |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                             |  |                                              |  |        |  |      |  |          |  |
| Md.                                                                                                                                                            |         | Baltimore                                                                                                  |  | Catonsville                                                                           |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1210 Westerlee Place Apt 1D                     |  |                                              |  |        |  |      |  |          |  |
| 14. FATHER'S NAME                                                                                                                                              |         | MIDDLE                                                                                                     |  | LAST                                                                                  |  | 15. MOTHER'S MAIDEN NAME                                            |  | MIDDLE                                          |  | LAST                                         |  |        |  |      |  |          |  |
| John                                                                                                                                                           |         | F.                                                                                                         |  | Landon                                                                                |  | Hilda                                                               |  |                                                 |  | Dinsbier                                     |  |        |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                          |         | (IF YES, GIVE WAR OR DATES)                                                                                |  | 16b. SOCIAL SECURITY NO.                                                              |  | 17. INFORMANT                                                       |  | ADDRESS                                         |  |                                              |  |        |  |      |  |          |  |
| YES                                                                                                                                                            |         | WW II                                                                                                      |  | 218-10-2513                                                                           |  | Mrs. Grace A. Landon, 1210 Westerlee Place                          |  | Apt 1D 21228                                    |  |                                              |  |        |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                      |         | PART 1 DEATH WAS CAUSED BY:                                                                                |  | IMMEDIATE CAUSE (a)                                                                   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                                              |  |        |  |      |  |          |  |
| 4409                                                                                                                                                           |         | Arteriosclerotic Vascular Disease                                                                          |  |                                                                                       |  |                                                                     |  |                                                 |  |                                              |  |        |  |      |  |          |  |
|                                                                                                                                                                |         | Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.   |  | (b)                                                                                   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |                                                 |  |                                              |  |        |  |      |  |          |  |
|                                                                                                                                                                |         |                                                                                                            |  | (c)                                                                                   |  |                                                                     |  |                                                 |  |                                              |  |        |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                 |         |                                                                                                            |  |                                                                                       |  |                                                                     |  |                                                 |  |                                              |  |        |  |      |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                         |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                          |  | 20. AUTOPSY?                                                                          |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                                 |  |                                              |  |        |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |  |                                                                     |  |                                                 |  |                                              |  |        |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                                             |  | 21f. LOCATION<br>STREET                                                               |  | CITY OR TOWN                                                        |  | COUNTY                                          |  | STATE                                        |  |        |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an                                                                                      |         | Autopsy <input type="checkbox"/>                                                                           |  | Inspection <input checked="" type="checkbox"/>                                        |  | Inquiry <input checked="" type="checkbox"/>                         |  | and in my opinion                               |  |                                              |  |        |  |      |  |          |  |
| death resulted from:                                                                                                                                           |         | Natural causes <input checked="" type="checkbox"/>                                                         |  | Accident <input type="checkbox"/>                                                     |  | Suicide <input type="checkbox"/>                                    |  | Homicide <input type="checkbox"/>               |  | Undetermined manner <input type="checkbox"/> |  |        |  |      |  |          |  |
| ACTUAL<br>SIGNATURE                                                                                                                                            |         | Conrado Ferrero                                                                                            |  | M.D.                                                                                  |  | Deputy                                                              |  | MEDICAL EXAMINER                                |  | DATE<br>SIGNED                               |  | 6-2-79 |  |      |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                             |         | Conrado Ferrero,                                                                                           |  | ADDRESS                                                                               |  | 5550 Baltimore National Pike                                        |  |                                                 |  |                                              |  |        |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                   |         | 23b. DATE                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                    |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY                                          |  | STATE                                        |  |        |  |      |  |          |  |
| Burial                                                                                                                                                         |         | 6/5/79                                                                                                     |  | Meadowridge Mem. Pk.                                                                  |  | Howard County,                                                      |  | Maryland                                        |  |                                              |  |        |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                   |         | ADDRESS                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR                                                         |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                                                 |  |                                              |  |        |  |      |  |          |  |
| Hubbard Funeral Home, Inc.                                                                                                                                     |         | 4107 Wilkens Ave.                                                                                          |  | JUN 4 1979                                                                            |  | Fitzgerald                                                          |  |                                                 |  |                                              |  |        |  |      |  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                          |  | 7 9 1 3 7 2 4                                                                                                                                              |  |                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                          |  | REG. NO.                                                                                                                                                   |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Joseph August Lauer</b><br>(Brother Edwin Faber)                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR 6 13 79<br>2b. HOUR 12:15 PM                                                                                              |  |                                                                                                                         |  |
| 3 SEX Male                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4 RACE White                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR 1 11 1898                                                                                                                  |  | 6 AGE (IN YEARS LAST BIRTHDAY) 81<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S. Baltimore                                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.                                                                                        |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.                                                                   |  |
| 10 CITY OR TOWN OF DEATH Towson, Maryland                                                                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8102 LaSalle Road |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Christian Brother                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a. STATE Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY Balto.                                                                                                       |  | 13c. CITY OR TOWN Towson                                                                                                                                   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST Alphonse A. Lauer                                                                                                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleonore                                                                      |  | 13e. STREET ADDRESS 8102 La Salle Road                                                                                                                     |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no                                                                                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO. 215-54-9088                                                                                     |  | 17 INFORMANT ADDRESS Brother Timothy Dean- Religious Superior                                                                                              |  |                                                                                                                         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerosis, Diabetes, Carcinoma of 20 years<br>Colon, Emphesema<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |                                                                                                                          |  |                                                                                                                                                            |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                             |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from January 19 74, to June 19 79, that (I), (we) lost saw the deceased alive on May 9 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.                                                                                                                                     |  |                                                                                                                          |  |                                                                                                                                                            |  |                                                                                                                         |  |
| 22b. SIGNATURE Thomas N. Perciot                                                                                                                                                                                                                                                                                                                                                                                                                        |  | DEGREE                                                                                                                   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED 6/13/79                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas N. Perciot, M. D.                                                                                                                                                                                                                                                                                                                                                                                          |  | 22e. ADDRESS 2045 York Road, Timonium, Maryland 21093                                                                    |  |                                                                                                                                                            |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL                                                                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE 6/16/79                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY Brothers Cemetery                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Ammendale, Maryland                                                             |  |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd. 21212                                                                                                                                                                                                                                                                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR JUN 19 1979                                                                                |  | 25b. REGISTERED SIGNATURE                                                                                                                                  |  |                                                                                                                         |  |

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*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 1/75  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         |  |                                                                                                                                                            |  |                                                                                                                           |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>HANNAH</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | FIRST MIDDLE LAST<br><b>LAUMAN</b>                                                                                                      |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>06/ 01 1979</b>                                                                                                      |  | 2b HOUR P<br><b>7:00 M</b>                                                                                                |                                              |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4 RACE<br><b>White</b>                                                                                                                  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>1 26 1890</b>                                                                                                         |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b>                                                                               |                                              |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CONNTY MD.</b>                                                        |                                              |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                                        |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Homemaking</b>                                                                     |                                              |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13b COUNTY<br><b>Baltimore</b>                                                                                                          |  | 13c CITY OR TOWN<br><b>Fullerton</b>                                                                                                                       |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                                              |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Snyder</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Miller</b>                                                                      |  | 13e STREET ADDRESS<br><b>8644 Belair Road</b>                                                                                                              |  |                                                                                                                           |                                              |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                    |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-32-9455</b>                                                            |  | 17 INFORMANT ADDRESS<br><b>Louis C. Lauman, Jr. 8650 Belair Rd.</b>                                                                                        |  |                                                                                                                           |                                              |
| 18 CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Thrombosis, Stroke</b><br><b>4340</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS <b>CONTRIBUTING TO DEATH</b> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |                                                                                                                                         |  |                                                                                                                                                            |  |                                                                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                             |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                           |                                              |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                         |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                           |                                              |
| 22a I certify that (I) (this hospital) attended the deceased from <b>5/31</b> , 19 <b>79</b> to <b>6/1</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                       |  |                                                                                                                                         |  |                                                                                                                                                            |  |                                                                                                                           |                                              |
| 22b SIGNATURE<br><b>A.H. Ghiladi</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                         |  | DEGREE                                                                                                                                                     |  | 22c DATE SIGNED<br><b>6-2-79</b>                                                                                          |                                              |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.M. GHILADI</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         |  | 22e ADDRESS<br><b>7401 OSLER Dr. 21204</b>                                                                                                                 |  |                                                                                                                           |                                              |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 23b DATE<br><b>6/5/79</b>                                                                                                               |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>St. Joseph's Cem.</b>                                                                                              |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Fullerton Baltimore Md.</b>                                               |                                              |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lassahn Funeral Home 7401 Belair Road</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |  | 25a DATE BY REGISTRAR<br><b>JUN 7 1979</b>                                                                                                                 |  | 25b REGISTRAR'S SIGNATURE<br><b>Kathy McBrady</b>                                                                         |                                              |



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BALTIMORE COUNTY  
TOWSON  
ST. JOSEPH HOSPITAL  
BALTIMORE, MD  
1970 10 10 10:00  
BALTIMORE COUNTY  
TOWSON  
ST. JOSEPH HOSPITAL  
BALTIMORE, MD  
1970 10 10 10:00  
BALTIMORE COUNTY  
TOWSON  
ST. JOSEPH HOSPITAL  
BALTIMORE, MD



1970 10 10 10:00  
BALTIMORE COUNTY  
TOWSON  
ST. JOSEPH HOSPITAL  
BALTIMORE, MD  
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TOWSON  
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BALTIMORE, MD

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  | REG. NO. 7 9 1 3 7 2 6                                                                                                                                        |  |                                                                                              |  |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>GEORGE F. LAWHORN</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 23, 1979</b>                                                                                                      |  |                                                                                              |  | 2b. HOUR<br><b>11:25A</b>                                                                                               |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br><b>White</b>                                                                                                                 |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 1, 1936</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>42</b>                                            |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kaymoor, W. Va.</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                          |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Contractor</b>                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-Employed</b>                                    |  |                                                                                                                         |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                        |  | 13c. CITY OR TOWN<br><b>ESSEX</b>                                                                                                                             |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7 Mingo Lane</b>                                                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Hobart Lawhorn</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Loraine Treadway</b>                                                                                         |  |                                                                                              |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes Korean</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>232-56-1913</b>                                                                                                                |  | 17. INFORMANT ADDRESS<br><b>Mrs. Loraine Smith (mother) Beckley, W. Va.</b>                  |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>9289 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE OBSTRUCTIVE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>(b) PNEUMONIA-CHRONIC PULMONARY DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>(c) CERVICAL SPINE INJURY WITH QUADRIPLEGIA</b>                                     |  |                                                                                                                                        |  |                                                                                                                                                               |  |                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |  |                                                                                                                                                               |  |                                                                                              |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |                                                                                                                                                               |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                |  |                                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                |  |                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 23, 1979</b> to <b>JUNE 23, 1979</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JUNE 23, 1979</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death. |  |                                                                                                                                        |  |                                                                                                                                                               |  |                                                                                              |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><b>M. Escalante</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                              |  | 22c. DATE SIGNED<br><b>6/23/79</b>                                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AGATON H. ESCALANTE M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  | 22e. ADDRESS<br><b>7620 YORK RD. TOWSON, MARYLAND ST. JOSEPH HOSPITAL</b>                                                                                     |  |                                                                                              |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br><b>6/26/1979</b>                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Blue Ridge Mem. Gardens</b>                                                                                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Prosperity W. Va.</b>                          |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME<br><b>E. Barnes Fleming Funeral Service</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  | ADDRESS<br><b>Benson, Md. 21018</b>                                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 27 1979</b>                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>H. J. McCreedy</b>                                                                     |  |

13150

APRIL 1972

GEORGE T. LAWSON

BALTIMORE COUNTY

TOWSON

RESIDENT

RESPIRATORY FAILURE  
CHRONIC BRONCHITIS  
OBSTRUCTIVE  
PULMONARY DISEASE  
CENTRAL VEIN THROMBOSIS

ADMISSION

DATE

TIME

DATE

TIME

DATE

TIME



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                     |                                                                                                                                                             |                                                                              |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Gene Vance Lease                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 2, 1979                          |                                                                                                                                                      | 2b. HOUR<br>11:15A M                                                                            |                                                                                                                            |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br>White                                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 16 1928                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.                                   |                                                                                                                                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                    |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.                                                                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                 |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Rossville                                                                                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF BOTH IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Sq. Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>Meat Shop |                                                                                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel                                                      |                                                                                                                            |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                     |                                                                                                                                                             | 13b. COUNTY<br>Baltimore                                                     | 13c. CITY OR TOWN<br>Rosedale                                                                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            |
| 14. FATHER'S NAME<br>Lloyd H. Lease                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>Mary Elizabeth Cunningham<br>4237                |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br>235-40-4674                                                                                                                     | 17. INFORMANT<br>ADDRESS<br>Mrs. Margaret Lease, 1234 Berk Ave.              |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>16 wks |                                                                                                                                     |                                                                                                                                                             |                                                                              |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br>N/A                                                                                                                                                                                                                                                                            |                                                                                                                                     |                                                                                                                                                             |                                                                              |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION<br>N/A                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>N/A                                                                                                     |                                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                               |                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                                 |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                              |                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                                 |                                                                                                                            |
| 22. I certify that (I) (this hospital) attended the deceased from April 6, 1979, to May 30, 1979, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.                                                                                                             |                                                                                                                                     |                                                                                                                                                             |                                                                              |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| 22a. SIGNATURE<br>S. WEINER                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                     |                                                                                                                                                             |                                                                              | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED                                                                                                           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. WEINER                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                     |                                                                                                                                                             |                                                                              | 22e. ADDRESS                                                                                                                                         |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                     | 23b. DATE<br>6/5/79                                                                                                                                         |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Mem.                                                                                                |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>White Marsh Balto Md                                                         |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck Inc. 7922 Wise Ave. 21222                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                     |                                                                                                                                                             |                                                                              | 25a. DATE REC'D. BY REGISTRAR<br>JUNE 1979                                                                                                           |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>T. J. McBrady                                                                                |



13151

James J. ...



James J. ...

Item 11 8532 6/22/79 g3

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 3 7 2 8

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |                                                      |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sybil W. Leber</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 6 79</b> |                                                                                                                                                             |                                                                                      | 2b. HOUR<br><b>4:30 AM</b>                                                                                                                 |                                                                                                                            |                                                     |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br><b>White</b>                                                                                                                   |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 27 19</b>                                                                                                       |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.                                                                                          |                                                                                                                            |                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Neshoba, Mississippi</b>                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                                                                                                |                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD.                                                                           |                                                                                                                            |                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Reisterstown</b>                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>704 Shirley Manor Rd</b> |                                                      |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                     |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                             |                                                      | 13c. CITY OR TOWN<br><b>Reisterstown</b>                                                                                                                    |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                       |                                                                                                                            | 13e. STREET ADDRESS<br><b>704 Shirley Manor Rd.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gene Deweese</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                          |                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Portia McAdory</b>                                                                                      |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br><b>425-40-4896</b>                                                                                           |                                                      | 17. INFORMANT<br>ADDRESS <b>704 Shirley Manor</b><br><b>Rev. Paul H. Leber, Sr., Reisterstown, Md.</b>                                                      |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malnutrition (Aphagia)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Glioblastoma Multiforme</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1919</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                          |                                                      |                                                                                                                                                             |                                                                                      |                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>one week</b><br><b>3 months</b>                                         |                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                          |  |                                                                                                                                          |                                                      |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |                                                      |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                        |                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 8</b> , 19 <b>77</b> , to <b>June 6</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>June 1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |                                                                                                                                          |                                                      |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                     |  |
| 22b. SIGNATURE<br><b>Martin E. Strobel</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |                                                      | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                                                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                            | 22c. DATE SIGNED<br><b>6-6-79</b>                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Martin E. Strobel, M.D.</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |                                                      | 22e. ADDRESS<br><b>59 Hanover Road, Reisterstown, Md.</b>                                                                                                   |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>6/9/79</b>                                                                                                               |                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Spring Creek Cemetery</b>                                                                                          |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Neshoba Mississippi</b>                                                                   |                                                                                                                            |                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Eline Funeral Home, Reisterstown, Md. 21136</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 8 1979</b>                                                                                                          |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Patrick McCreedy</b>                                                                                      |                                                                                                                            |                                                     |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |  |                                                                                                                                                            |                                                           |                                                                               |                                                                                                 |                                                                                                                            |                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  |                                                                                                                                                            | REG. NO. 7 9 1 3 7 2 9                                    |                                                                               |                                                                                                 |                                                                                                                            |                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GOLDIE REBECCA LEE                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |  |                                                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR<br>JUNE 23, 1979         |                                                                               |                                                                                                 | 2b. HOUR<br>11:30 AM                                                                                                       |                                         |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                             |  | 4 RACE<br>White                                                                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept. 7, 1905                                                                                                           |                                                           | 6 AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.                                     |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                    |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                           | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |                                                                                                 |                                                                                                                            |                                         |  |
| 10 CITY OR TOWN OF DEATH<br>Cockeysville                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Masonic Homes of Maryland |  |                                                                                                                                                            |                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                                                                                  |                                         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  |                                                                                                                                                            | 13b. COUNTY<br>Baltimore                                  |                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br>621 N. East Ave. |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Harry Mulligan                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |  |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Cora Howard |                                                                               |                                                                                                 |                                                                                                                            |                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-10-1451                                                                 |  | 17 INFORMANT ADDRESS<br>Masonic Homes of Md., Inc. Cockeysville, Md.                                                                                       |                                                           |                                                                               |                                                                                                 |                                                                                                                            |                                         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic Heart Failure</u><br>410 -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Non-fatal Corary Thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Myocardial Infarction</u>                                                      |  |                                                                                                                                        |  |                                                                                                                                                            |                                                           |                                                                               |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6/21/79</u><br><u>6/21/79</u><br><u>6/22/79</u>                         |                                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                          |  |                                                                                                                                        |  |                                                                                                                                                            |                                                           |                                                                               |                                                                                                 |                                                                                                                            |                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |                                                                                                                                                            |                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                             |                                                           |                                                                               |                                                                                                 |                                                                                                                            |                                         |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>6/23/79</u>                                                                                        |                                                           |                                                                               |                                                                                                 |                                                                                                                            |                                         |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>12/15/75</u> , 19 <u>75</u> , to <u>6/23/79</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/23/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                        |  |                                                                                                                                                            |                                                           |                                                                               |                                                                                                 |                                                                                                                            |                                         |  |
| 22b. SIGNATURE<br><u>Walter E. Karfgin, M.D.</u>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |                                                           | 22c. DATE SIGNED<br><u>6/24/79</u>                                            |                                                                                                 |                                                                                                                            |                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Walter E. Karfgin, M.D.                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |  | 22e. ADDRESS<br>Masonic Homes of Md. Cockeysville, Md.                                                                                                     |                                                           |                                                                               |                                                                                                 |                                                                                                                            |                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br>June 26, 1979                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet                                                                                                           |                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick, Washington, Maryland |                                                                                                 |                                                                                                                            |                                         |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mitchell-Wiedefeld Home, Inc. Balto., Md.                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 26 1979                                                                                                               |                                                           | 25b. REGISTRAR'S SIGNATURE<br><u>John H. Melnyk</u>                           |                                                                                                 |                                                                                                                            |                                         |  |

MEDICAL CERTIFICATION

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

1 3 7 3 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                               |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Lulu Uhler Lee                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                               |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 24, 1979                          |                                                                                      | 2b. HOUR<br>10A M                                                                                                          |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                               | 4. RACE<br>White                                                                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 22 1900                                                                                                             |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                        |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>34 E. Burke Ave. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----                                                                                 |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                   |                                                                                                                               |                                                                                                                                                             | 13b. COUNTY<br>Baltimore                                                      | 13c. CITY OR TOWN<br>Towson                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John M. Burns                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                               |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Uphiminia Uhler              |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----<br>219-36-2352                                                                             |                                                                               | 17. INFORMANT<br>ADDRESS<br>Mrs. Elizabeth Gorsuch, Dam Rd. 17409 Prettyboy          |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                                               |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                       |                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                   |                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/3/57</u> , 19____, to <u>6/24/79</u> , that (I) (we) last saw the deceased alive on <u>3/19/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                                                                                |                                                                                                                               |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><u>T. C. Siwinski</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                                                                                |                                                                                                                               |                                                                                                                                                             |                                                                               | 22c. DATE SIGNED<br>6/26/79                                                          |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thaddeus C. Siwinski, M.D.                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                             | 22e. ADDRESS<br>206 W. Pennsylvania Avenue                                    |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                            | 23b. DATE<br>6/27/79                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br>Prospect Hill Cem.                                                                                                    |                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Towson Md.                             |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. E. Lowell Lemmon                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 28 1979                                  |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><u>Elizabeth Gorsuch</u>                                                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires: that the death certificate be executed within 24 hours after death. Page number of certificate retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



5 4 3 2 1







FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |                                                      |                                                                                                                                                            |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Lillie LeMay</i>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>6 7 79</i> |                                                                                                                                                            |  | 2b. HOUR<br><i>6:39</i><br>M                                                                                               |  |
| 3 SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4 RACE<br><i>White</i>                                                                                                                      |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5 10 85</i>                                                                                                       |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>94</i> YRS.                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>S. Carolina</i>                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                  |                                                      | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                                                         |  |
| 10 CITY OR TOWN OF DEATH<br><i>Ruxton</i>                                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Manor Care N.H. -Ruxton</i> |                                                      |                                                                                                                                                            |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i>                                       |  |
| 13a. STATE<br><i>Md</i>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br><i>Balto City</i>                                                                                                            |                                                      | 13c. CITY OR TOWN<br><i>Baltimore</i>                                                                                                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John Dolan</i>                                                                                                                                                                                                                                                                                                                                                              |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Jenne Keegan</i>                                                                         |                                                      | 13e. STREET ADDRESS<br><i>214 E. Biddle St 21202</i>                                                                                                       |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>---</i>                                                                       |                                                      | 17 INFORMANT <i>Baltimore, Md</i> ADDRESS <i>21234</i><br><i>John Southford 2299 Lowell Ridge Rd.</i>                                                      |  |                                                                                                                            |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia</i><br>486-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 days</i> |  |                                                                                                                                             |                                                      |                                                                                                                                                            |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><i>Diabetes - ASCVD</i>                                                                                                                                                                                                                                                         |  |                                                                                                                                             |                                                      |                                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                  |                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that on this hospital) attended the deceased from <i>4/13</i> 19 <i>73</i> , to <i>6/7</i> 19 <i>79</i> , that (1) <del>was</del> lost saw the deceased alive on <i>5/22</i> 19 <i>74</i> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above; (1) (if deceased) did not see the body after death.                                              |  |                                                                                                                                             |                                                      |                                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>Richard M. Maffezzoli</i>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             |                                                      | DEGREE                                                                                                                                                     |  | 22c. DATE SIGNED<br><i>6/8/79</i>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Richard Maffezzoli</i>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |                                                      | 22e. ADDRESS<br><i>1205 York Rd Luthersville, Md 21093</i>                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><i>6/11/1979</i>                                                                                                               |                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Frostburg Mem. Park</i>                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Frostburg Allegany Md</i>                                                 |  |
| 24 FUNERAL DIRECTOR<br>NAME <i>Loring Byers Funeral Directors, P.A.</i> ADDRESS <i>8728 Liberty Road Randallstown, Md. 21133</i>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             |                                                      | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 11 1979</i>                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McBrady</i>                                                                       |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Items #14&15 Film G532 6/1/79 rc STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                     |  |                                                                                                                                           |  |                                                                                                                                                              |                                                                      |                                                                                      |  |                                                                                      |  | 7 9 1 3 7 3 2                                                                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |  |                                                                                                                                                              |                                                                      |                                                                                      |  |                                                                                      |  | REG. NO.                                                                                                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>ARLENE CATHERINE LEMBITZ</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                           |  |                                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH <b>MAY</b> DAY <b>27</b> YEAR <b>1979</b> |                                                                                      |  | 2b. HOUR<br><b>M</b>                                                                 |  |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>White</b>                                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH <b>August</b> DAY <b>29</b> YEAR <b>1911</b>                                                                                       |                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                    |  | 8. IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>                                                                           |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>                                                                                                                                                                                                                                                                                              |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                      | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                 |  |                                                                                      |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SAINT JOSEPH HOSPITAL</b> |  |                                                                                                                                                              |                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                    |  |                                                                                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b>                                                                                                                                                                                                   |  |                                                                                                                                           |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                              |                                                                      | 13d. STREET ADDRESS<br><b>4620 Harcourt Rd. 21214</b>                                |  |                                                                                      |  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST <b>Fred</b> MIDDLE <b>Unknown</b> LAST <b>Jensen</b>                                                                                                                                                                                                                                                                           |  |                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Elizabeth</b> MIDDLE <b>Unknown</b> LAST <b>Finn</b>                                                                    |                                                                      |                                                                                      |  |                                                                                      |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><b>217-64-2432</b>                                                                                                               |                                                                      | 17. INFORMANT<br>ADDRESS<br><b>Richard J. Lembitz 1229 St. Francis Rd.</b>           |  |                                                                                      |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC TAMPONADE</b>                                                                                                                                                                                                 |  |                                                                                                                                           |  |                                                                                                                                                              |                                                                      |                                                                                      |  |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| 4411<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>RUPTURE OF THE ASCENDING AORTA</b><br>(c) <b>AORTIC ATHEROSCLEROSIS</b>                                                                                                                                                                  |  |                                                                                                                                           |  |                                                                                                                                                              |                                                                      |                                                                                      |  |                                                                                      |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                      |  |                                                                                                                                           |  |                                                                                                                                                              |                                                                      |                                                                                      |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                             |                                                                      |                                                                                      |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                  |  |                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                            |                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                 |  |                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                       |                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                      |  |                                                                                                                            |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>MAY 26</b> 19 <b>79</b> , to <b>MAY 27</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>MAY 27</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death. |  |                                                                                                                                           |  |                                                                                                                                                              |                                                                      |                                                                                      |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                           |  |                                                                                                                                                              |                                                                      | DEGREE<br><b>M.D.</b>                                                                |  | 22c. DATE SIGNED                                                                     |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>REYNALDO ORJUELA-GOMEZ, M.D.</b>                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |  |                                                                                                                                                              |                                                                      | 22e. ADDRESS<br><b>7620 YORK ROAD, TOWSON MARYLAND 21204</b>                         |  |                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |  | 23b. DATE<br><b>May 31, 1979</b>                                                                                                                             |                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>             |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b> ADDRESS<br><b>Balto, Md.</b>                                                                                                                                                                                                                                                                 |  |                                                                                                                                           |  |                                                                                                                                                              |                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                     |  |                                                                                                                            |  |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                       |  |                                                                                                                                             |        |                                                                                                                                                             |                   |                                                                                                 |                   |                                    |                   |                               |  |
|---------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------|-------------------|------------------------------------|-------------------|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                   |  | FIRST<br><i>Jacob</i>                                                                                                                       | MIDDLE | LAST<br><i>Lerner</i>                                                                                                                                       | 2a. DATE OF DEATH |                                                                                                 | MONTH<br><i>6</i> | DAY<br><i>10</i>                   | YEAR<br><i>79</i> | 2b. HOUR<br><i>11 P</i>       |  |
| 3. SEX<br><b>MALE</b>                                                                 |  | 4. RACE<br><b>WHITE</b>                                                                                                                     |        | 5. DATE OF BIRTH                                                                                                                                            |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                 |                   | IF UNDER 1 YEAR                    |                   | IF UNDER 24 HRS               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 89 YRS.                                                                                         |                   |                                    |                   |                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>PIKESVILLE</b>                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PIKESVILLE NURSING HOME</b> |        |                                                                                                                                                             |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>                                 |                   | MD.                                |                   |                               |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>VEST MAKER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHES</b>                                                                                         |        | 13a. STREET ADDRESS<br><b>5446 NARCISSUS AVE. #21215</b>                                                                                                    |                   | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   | 13c. CITY OR TOWN<br><b>BALTO.</b> |                   | 13d. STATE<br><b>MARYLAND</b> |  |
| 14. FATHER'S NAME<br>FIRST<br><i>UNKNOWN</i>                                          |  | MIDDLE                                                                                                                                      |        | LAST<br><b>LERNER</b>                                                                                                                                       |                   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>FRUMA</b>                                               |                   | MIDDLE                             |                   | LAST<br><b>UNKNOWN</b>        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>     |  | 16b. SOCIAL SECURITY NO.<br><b>217-30-4445</b>                                                                                              |        | 17. INFORMANT<br><b>LEON LERNER</b>                                                                                                                         |                   | ADDRESS<br><b>1190 W. NORTHERN PARKWAY, APT. 417 #21210</b>                                     |                   |                                    |                   |                               |  |

|                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>gangrene of L foot</i><br><b>4439</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>peripheral vascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 mo.</i> |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  
*Parkinson's disease*

|                                                                                                                                                                                                                                                                                                                                                          |  |                                                                          |  |                                                                                                                                            |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M.</i> <i>19</i> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3</i> 19 <i>79</i> , to <i>6/10</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>6/4</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                          |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>Stuart Ross</i>                                                                                                                                                                                                                                                                                                                     |  | DEGREE<br><i>MD</i>                                                      |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>6/11/79</i>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Stuart Ross</i>                                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS<br><i>10215 Rosedale Rd Owings Mills, MD 21127</i>          |  |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>JUNE 12, 1979</b>                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ANSHE NEISEN</b>                                                                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b>                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>                                                                                                                                                                                                                                                                                    |  |                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 13 1979</b>                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><i>Fitzroy Halbury</i>                                                                       |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215                                                                                                                                                                                                                                                                                                                   |  |                                                                          |  |                                                                                                                                            |  |                                                                                                                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                            | 79 13734                                                                     |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                            | REG. NO.                                                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SOPHIA LISS</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 3, 1979</b> 2b. HOUR <b>3:40 AM</b> |  |
| 3. SEX <b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE <b>WHITE</b>                                                                                                                                                                                                                                                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>UNKNOWN</b>                                                                                                                                                             |                                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                                                                                                                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                                                                                     |                                                                              |  |
| 10. CITY OR TOWN OF DEATH <b>PIKESVILLE</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MILFORD MANOR NURSING HOME</b>                                                                                                                                                                                                                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.                                                                                                                                           |                                                                              |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>                                                                                                                                                                                                                                                                                                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                            |                                                                              |  |
| 13a. STATE <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY <b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                     |  | 13c. CITY OR TOWN <b>BALTIMORE</b>                                                                                                                                                                         |                                                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>VELVEL CAPLAN</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH UNKNOWN</b>                                                                                                                                                                                                                                                                                                  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                               |                                                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO. <b>217-32-81270</b>                                                                                                                                                                                                                                                                                                                     |  | 17. INFORMANT <b>JUDGE SOLOMON LISS</b> 3207 FALLSTAFF RD. BALTO., MD 21215                                                                                                                                |                                                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary heart failure</b><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MASCD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year +</b> |  |                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                            |                                                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                            |                                                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                     |                                                                              |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                           |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.                                                                                                                                                |                                                                              |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                                                                                                    |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                        |                                                                              |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                                    |  | 22a. certify that (I) (this hospital) attended the deceased from <b>1/8</b> , 19 <b>78</b> , to <b>6/3</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/3/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE <b>Dr. Joseph C. Matchar MD</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                              |  |
| 22c. DATE SIGNED <b>6/4/79</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. JOSEPH C. MATCHAR</b>                                                                                                                                                                                                                                                                                               |  | 22e. ADDRESS <b>3635 OLD COURT RD. BALTO., MD 21208</b>                                                                                                                                                    |                                                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE <b>JUNE 4, 1979</b>                                                                                                                                                                                                                                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY <b>WORKMEN CIRCLE</b>                                                                                                                                                   |                                                                              |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>                                                                                                                                                                                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>                                                                                                                                                            |                                                                              |  |
| 25b. REGISTRAR'S SIGNATURE <b>Priscilla Hardy</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 25c. ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                            |                                                                              |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |  | REG. NO. 13735                                                                                                                                           |  |                                                                                                                         |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |  | 79                                                                                                                                                       |  |                                                                                                                         |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST (Oney) LAST LONG.                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR 6 7 79 2b. HOUR 12-10 P.M.                                                                                              |  |                                                                                                                         |                                              |
| 3. SEX FEMALE                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE BLACK                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR 10 28 07                                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.                                                                                 |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY? USA                                                                                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY. MD.                                                              |                                              |
| 10. CITY OR TOWN OF DEATH MT. WILSON                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MT. WILSON HOSPITAL 21112. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| 13a. STATE Md.                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  | 13b. COUNTY Balto.                                                                                                                                       |  | 13c. CITY OR TOWN                                                                                                       |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST Major W. Dobney                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Millie                                                                                                        |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO. 220-142695                                                                                               |  | 17. INFORMANT ADDRESS Madeline Gibson 2429 E. Hoffman St.                                                                                                |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4254 CHRONIC CONGESTIVE HEART FAILURE.<br>DUE TO, OR AS A CONSEQUENCE OF (b) ISCHAEMIC CARDIOMYOPATHY.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HYPOTHYROIDISM.                                                                                                                                                                                                                           |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/31/79, 19____, to 6/7, 1979, that (I) (we) last saw the deceased alive on 6/7, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                            |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 22b. SIGNATURE K. L. PATEL                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                   |  | DEGREE                                                                                                                                                   |  | 22c. DATE SIGNED 6/7/79.                                                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. L. PATEL                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  | 22e. ADDRESS MT. WILSON HOSPITAL. MT. WILSON. MD 21112.                                                                                                  |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE 6/13/79                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.                                                                                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.                                                                    |                                              |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                   |  | ADDRESS 1101 E. North Ave.                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR JUN 11 1979                                                                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |                                                                                                                         |                                              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                        |                                                                                                                                                      |                                                                     |                                                                                                                            |                                                                                                 |                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                               |                                                                        |                                                                                                                                                             | 7 9 1 3 7 3 6<br>REG. NO.                                              |                                                                                                                                                      |                                                                     |                                                                                                                            |                                                                                                 |                                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Maurice L. Long                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                               |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 14, 1979                   |                                                                                                                                                      |                                                                     | 2b. HOUR<br>M                                                                                                              |                                                                                                 |                                                     |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>White                                                                                                              |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 13, 1894                                                                                                        |                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS                                                                                                            |                                                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                                                                 |                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                        |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                                                                        |                                                                     |                                                                                                                            |                                                                                                 |                                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Lutherville                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>10901 Falls Road |                                                                        |                                                                                                                                                             |                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Paint & Repair                                                                   |                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>Truck Bodies                                                                          |                                                                                                 |                                                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                               |                                                                        |                                                                                                                                                             | 13b. COUNTY<br>Baltimore                                               |                                                                                                                                                      | 13c. CITY OR TOWN<br>Lutherville                                    |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John L. Long                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                               |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Henretta K. Cronhardt |                                                                                                                                                      |                                                                     |                                                                                                                            |                                                                                                 |                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW I                                                               |                                                                        | 17. INFORMANT<br>Helen L. Long                                                                                                                              |                                                                        | ADDRESS<br>Same as #13.                                                                                                                              |                                                                     |                                                                                                                            |                                                                                                 |                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br><u>1509</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinomatosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Carcinoma, esophagus</u>                                                                    |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                        |                                                                                                                                                      |                                                                     |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 months<br>3 months                            |                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                        |                                                                                                                                                      |                                                                     |                                                                                                                            |                                                                                                 |                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            |                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                     |                                                                                                                            |                                                                                                 |                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                     |                                                                                                                            |                                                                                                 |                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>December 3, 1962</u> , to <u>June 14, 1979</u> , that (I) ( <input checked="" type="checkbox"/> ) last saw the deceased alive on <u>June 11, 1979</u> , and that in (my) ( <input checked="" type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <input checked="" type="checkbox"/> ) ( <input type="checkbox"/> ) did not view the body after death. |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                        |                                                                                                                                                      |                                                                     |                                                                                                                            |                                                                                                 |                                                     |  |
| 22b. SIGNATURE<br><u>Donald O. Wood, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                     | 22c. DATE SIGNED<br><u>6/15/79</u>                                                                                         |                                                                                                 |                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Donald O. Wood, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                        | 22e. ADDRESS<br>York Rd. & Greenmeadow Drive Tim., Md.                                                                                               |                                                                     |                                                                                                                            |                                                                                                 |                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                               | 23b. DATE<br>June 18, 1979                                             |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Prospect Hill Cem.               |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Towson Baltimore, Md. |                                                                                                                            |                                                                                                 |                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                        | ADDRESS<br>1050 York Road<br>Towson, Md. 21204                                                                                                       |                                                                     | 25a. DATE REC'D. BY REGISTRAR<br>JUN 18 1979                                                                               |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>Robert H. B...</u> |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 3 7 3 7

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                       |                                                                                          |                                                                                                 |                                                                                                                            |                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HERBERT DILLER LOWRY</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 2, 1979</b>             |                                                                                                                                                             |                                                       | 2b. HOUR<br><b>10:00 PM</b>                                                              |                                                                                                 |                                                                                                                            |                                                             |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>White</b>                                                                                                                  |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 22, 1912</b>                                                                                                   |                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                        |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                      |                                                                                                 |                                                                                                                            |                                                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6552 St. Helena Ave.</b> |                                                                        |                                                                                                                                                             |                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self Employed</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home Improve.</b>                                                                  |                                                             |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          | 13b. COUNTY<br><b>Baltimore</b>                                        |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                 |                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>3604 Belair Rd.</b>               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Diller Lowry</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pearl White</b>    |                                                                                                                                                             |                                                       | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>            |                                                                                                 |                                                                                                                            |                                                             |  |
| 16b. SOCIAL SECURITY NO.<br><b>213-07-2342A</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                          | 17. INFORMANT<br><b>Edward D. Lowry, 8 Stony Brook Rd.</b>             |                                                                                                                                                             |                                                       | 17a. ADDRESS<br><b>Morris Plains, N.J.</b>                                               |                                                                                                 |                                                                                                                            |                                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cardiac Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>19 years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                       |                                                                                          |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>stat</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>Had original myocardial infarction in 1963</b>                                                                                                                                                                                                                     |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                       |                                                                                          |                                                                                                 |                                                                                                                            |                                                             |  |
| 19a. DATE OF OPERATION<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                      |  |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)           |                                                                                                 |                                                                                                                            |                                                             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                        |                                                                                                 |                                                                                                                            |                                                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/11/63</b> to <b>5/11/79</b> , that (I) (we) last saw the deceased alive on <b>5/11/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                  |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                       |                                                                                          |                                                                                                 |                                                                                                                            |                                                             |  |
| 22b. SIGNATURE<br><b>Melvin F. Polek, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                          | 22c. DATE SIGNED<br><b>June 4, 1979</b>                                |                                                                                                                                                             |                                                       | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Melvin F. Polek, Sr., M.D.</b>               |                                                                                                 |                                                                                                                            | 22e. ADDRESS<br><b>3603 Belair Rd.</b>                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          | 23b. DATE<br><b>June 6, 1979</b>                                       |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b> |                                                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville, Balto., Md.</b>                     |                                                                                                                            | 23e. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1979</b>          |  |
| 23f. REGISTRAR'S SIGNATURE<br><b>Robert C. Altenburg</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          | 23g. REGISTRAR'S SIGNATURE<br><b>Robert C. Altenburg</b>               |                                                                                                                                                             |                                                       | 23h. REGISTRAR'S SIGNATURE<br><b>Robert C. Altenburg</b>                                 |                                                                                                 |                                                                                                                            | 23i. REGISTRAR'S SIGNATURE<br><b>Robert C. Altenburg</b>    |  |

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BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                           |         |                                                                   |                 |                                                          |                     |                                                                                             |  |                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-------------------------------------------------------------------|-----------------|----------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------|--|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                               |         | 2a. DATE KNOWN OF DEATH                                           |                 | 2b. DATE ESTIMATED                                       |                     | 2c. DATE PRONOUNCED DEAD                                                                    |  | 2d. HOUR                      |  |
| LOUISE                                                                                                                                                                                                                                                                                                                                                                                                                                            |         | 6-27 1979                                                         |                 | 6-27 1979                                                |                     | 6-27 1979                                                                                   |  | 7:05 PM                       |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE | 5. DATE OF BIRTH                                                  | 6. AGE IN YEARS | 7. IF UNDER 1 YR.                                        | 8. IF UNDER 24 HRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                        |  | 10. CITY OR TOWN OF DEATH     |  |
| Female                                                                                                                                                                                                                                                                                                                                                                                                                                            | White   | August 10, 1911                                                   | 64 YRS.         |                                                          |                     | Baltimore County                                                                            |  | Middle River                  |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                                                                                                                                                                                                                                                                                                                                                                                          |         | 12a. USUAL OCCUPATION                                             |                 | 12b. KIND OF BUSINESS OR INDUSTRY                        |                     | 13a. INSIDE CITY LIMITS?                                                                    |  | 13b. STREET ADDRESS           |  |
| 4 Compression Court 21220                                                                                                                                                                                                                                                                                                                                                                                                                         |         | Homenaker                                                         |                 | Our Home                                                 |                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  | 114 3rd Avenue S.W. 21061     |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | 15. MOTHER'S MAIDEN NAME                                          |                 | 16. SOCIAL SECURITY NO.                                  |                     | 17. INFORMANT                                                                               |  | 18. CAUSE OF DEATH            |  |
| Wilbur C. Brown                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | Daisey V. Smiley                                                  |                 | 217 22 0717                                              |                     | Alfred J. Ludgrove                                                                          |  | Pneumonia                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                            |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                  |                 | 20. AUTOPSY?                                             |                     | 21a. EXTERNAL CAUSE WAS                                                                     |  | 21b. TIME OF INJURY           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                   |                 | YES <input type="checkbox"/> NO <input type="checkbox"/> |                     | UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | HOUR A.M. MONTH DAY YEAR      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                   |                 |                                                          |                     |                                                                                             |  | P.M. 19                       |  |
| 21c. HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                          |         | 21d. INJURY OCCURRED                                              |                 | 21e. PLACE OF INJURY                                     |                     | 21f. LOCATION                                                                               |  | 21g. LOCATION                 |  |
| ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2                                                                                                                                                                                                                                                                                                                                                                                                |         | WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> |                 | STREET, FACTORY, FARM, ETC.)                             |                     | STREET                                                                                      |  | CITY OR TOWN                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |                 |                                                          |                     |                                                                                             |  | COUNTY                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                   |                 |                                                          |                     |                                                                                             |  | STATE                         |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                                                                   |                 |                                                          |                     |                                                                                             |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                                                                                                                                                                                                                   |         | 23b. DATE                                                         |                 | 23c. NAME OF CEMETERY OR CREMATORY                       |                     | 23d. LOCATION                                                                               |  | 23e. DATE REC'D. BY REGISTRAR |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                            |         | June 30, 1979                                                     |                 | Glen Haven Mem. Ph.                                      |                     | Glen Burnie, Maryland                                                                       |  | 29 1979                       |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                              |         | 24a. NAME                                                         |                 | 24b. ADDRESS                                             |                     | 24c. CITY OR TOWN                                                                           |  | 24d. STATE                    |  |
| McUllly Funeral Home of Brooklyn Balto., Md.                                                                                                                                                                                                                                                                                                                                                                                                      |         | 237 East Patapsco Avenue                                          |                 | 21220                                                    |                     | Glen Burnie                                                                                 |  | Maryland                      |  |

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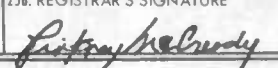
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                         |         |                                                                                                            |                                    |                                                                                                                                                             |  |                                                                                                 |  |                                                                                           |  |                                                                                                  |  |                                                                                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                            |         | 1 3 7 3 9                                                                                                  |                                    |                                                                                                                                                             |  |                                                                                                 |  |                                                                                           |  |                                                                                                  |  |                                                                                                                                    |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                     |         |                                                                                                            |                                    |                                                                                                                                                             |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED                                                       |  |                                                                                           |  |                                                                                                  |  | 2b. HOUR                                                                                                                           |  |
| DEBORAH DIANN LUFKIN                                                                                                                                                                                                                                                                                                                                                    |         |                                                                                                            |                                    |                                                                                                                                                             |  | MONTH DAY YEAR<br>6 2 1979                                                                      |  |                                                                                           |  |                                                                                                  |  | M<br>6:15<br>a                                                                                                                     |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                         | 6. AGE (IN YEARS<br>LAST BIRTHDAY) | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                                                                                                     |  | IF UNDER 24 HRS                                                                                 |  | 7c. DATE<br>PRONOUNCED<br>DEAD                                                            |  |                                                                                                  |  | 2d. HOUR                                                                                                                           |  |
| female                                                                                                                                                                                                                                                                                                                                                                  | white   | Nov. 13 1950                                                                                               | 28 YRS.                            |                                                                                                                                                             |  |                                                                                                 |  | MONTH DAY YEAR<br>6 2 1979                                                                |  |                                                                                                  |  | M<br>6:15<br>a                                                                                                                     |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                            |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |                                                                                                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                      |  |                                                                                                  |  |                                                                                                                                    |  |
| Arkansas                                                                                                                                                                                                                                                                                                                                                                |         | U.S.A.                                                                                                     |                                    |                                                                                                                                                             |  |                                                                                                 |  | Baltimore County MD                                                                       |  |                                                                                                  |  |                                                                                                                                    |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                               |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |                                                                                                                                                             |  |                                                                                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                          |  |                                                                                                  |  | 12b. KIND OF BUSINESS                                                                                                              |  |
| Parkville                                                                                                                                                                                                                                                                                                                                                               |         | front of 9112 Belair Rd.                                                                                   |                                    |                                                                                                                                                             |  |                                                                                                 |  | Salesperson                                                                               |  |                                                                                                  |  | Holiday<br>Health Spa                                                                                                              |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                              |         |                                                                                                            |                                    |                                                                                                                                                             |  |                                                                                                 |  |                                                                                           |  |                                                                                                  |  |                                                                                                                                    |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                              |         | 13b. COUNTY                                                                                                |                                    | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13a. STREET ADDRESS                                                                       |  |                                                                                                  |  | 21214                                                                                                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                |         | Baltimore                                                                                                  |                                    | Parkville                                                                                                                                                   |  |                                                                                                 |  | 3006 Ruckert Ave.                                                                         |  |                                                                                                  |  |                                                                                                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                  |         |                                                                                                            |                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |  |                                                                                                 |  |                                                                                           |  |                                                                                                  |  |                                                                                                                                    |  |
| Richard Weiss                                                                                                                                                                                                                                                                                                                                                           |         |                                                                                                            |                                    | Alma Brock                                                                                                                                                  |  |                                                                                                 |  |                                                                                           |  |                                                                                                  |  |                                                                                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                   |         |                                                                                                            |                                    | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                                                                                                     |  | 17. INFORMANT<br>ADDRESS                                                                        |  |                                                                                           |  |                                                                                                  |  |                                                                                                                                    |  |
| No                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                                                            |                                    | 412-90-7496                                                                                                                                                 |  | Richard Weiss                                                                                   |  |                                                                                           |  | 2200 Bromley Lane<br>Memphis, Tn. 38104                                                          |  |                                                                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cranio-cerebral trauma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |         |                                                                                                            |                                    |                                                                                                                                                             |  |                                                                                                 |  |                                                                                           |  |                                                                                                  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                     |         |                                                                                                            |                                    |                                                                                                                                                             |  |                                                                                                 |  |                                                                                           |  |                                                                                                  |  |                                                                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  |         |                                                                                                            |                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |  |                                                                                                 |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  |                                                                                                  |  |                                                                                                                                    |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                    |         |                                                                                                            |                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>2:15xx 6-2- 1979                                                                                         |  |                                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)             |  |                                                                                                  |  |                                                                                                                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                 |         |                                                                                                            |                                    | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>road                                                                                      |  |                                                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>9112 Belair Rd. Parkville Balto. Md. |  |                                                                                                  |  |                                                                                                                                    |  |
| 22a. I certify that I took charge of the remains described above, held on<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                  |         |                                                                                                            |                                    |                                                                                                                                                             |  |                                                                                                 |  |                                                                                           |  |                                                                                                  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |
| ACTUAL<br>SIGNATURE                                                                                                                                                                                                                                                                  |         |                                                                                                            |                                    |                                                                                                                                                             |  |                                                                                                 |  |                                                                                           |  |                                                                                                  |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER                                                                                      |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                   |         |                                                                                                            |                                    |                                                                                                                                                             |  |                                                                                                 |  |                                                                                           |  |                                                                                                  |  | DATE<br>SIGNED 6-2-79                                                                                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                            |         |                                                                                                            |                                    | 23b. DATE                                                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY                                                              |  |                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                       |  |                                                                                                                                    |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                  |         |                                                                                                            |                                    | 6/5/79                                                                                                                                                      |  | Forest Hill East Cem.                                                                           |  |                                                                                           |  | Memphis Shelby Tennessee                                                                         |  |                                                                                                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                                                    |         |                                                                                                            |                                    |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR                                                                   |  |                                                                                           |  | 25b. REGISTRAR'S SIGNATURE                                                                       |  |                                                                                                                                    |  |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.                                                                                                                                                                                                                                                                                                                            |         |                                                                                                            |                                    |                                                                                                                                                             |  | BALTO., MD. 21229                                                                               |  |                                                                                           |  | JUN 4 1979  |  |                                                                                                                                    |  |

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 13740

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Helen Martin Lupo

2a. DATE OF DEATH MONTH DAY YEAR

6/20/79 4P M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
5 31 1891

6. AGE (IN YEARS LAST BIRTHDAY)

88

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN  
COUNTRY)

New Jersey

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County

MD.

10. CITY OR TOWN OF DEATH

Parkton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

17220 York Road (Residence)

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR  
INDUSTRY

----

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Balto.

13c. CITY OR TOWN

Parkton

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

17220 York Road, Parkton

14. FATHER'S NAME

FIRST

MIDDLE

LAST

John Martin

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

---

215-48-0535

17. INFORMANT

ADDRESS

Mr. Wm. L. Tarbert, 17220 York Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

A. S. N. D.

4140

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Diabetes Mellitus

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19 60, to 6/20/79, 19 \_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on 6/19/79, 19 \_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

A. M. France

DEGREE

M.D.

ATTENDING  
PHYSICIANMEDICAL  
DIRECTORSTAFF  
PHYSICIAN

22c. DATE SIGNED

6/20/79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

A. M. FRANCE

22e. ADDRESS

PARKTON, MD 21120

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

6/23/79

23c. NAME OF CEMETERY OR CREMATOR

St. Joseph's Cemetery

23d. LOCATION  
CITY OR TOWN

Cockeysville, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

J. E. Lowell Lemmon, 10 W. Padonia Rd.

ADDRESS

25a. DATE REC'D. BY REGISTRAR

JUN 23 1979

25b. REGISTRAR'S SIGNATURE

Hickory McCreedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U P A C I V V



.bM ,ellivay



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

| Items 21a. - 21f. & 22a.                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                |  |                                                                                                                            |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                      |  | CERTIFICATE OF DEATH                                                                                                                                        |  |                                                                                                                            |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |  | 2a. DATE OF DEATH                                                                                                                                           |  |                                                                                                                            |                                              |
| FIRST <u>ERMINIE</u> MIDDLE <u>A.</u> LAST <u>MACIVER</u><br><u>MacIver Florence</u>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  | MONTH <u>5</u> DAY <u>21</u> YEAR <u>79</u> 2b. HOUR <u>5 P</u> M                                                                                           |  |                                                                                                                            |                                              |
| 3. SEX <u>F.</u>                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE <u>W</u>                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH <u>1</u> DAY <u>22</u> YEAR <u>98</u>                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>81</u> YRS                                                                           |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MASS</u>                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTO. COUNTY</u> MD.                                                           |                                              |
| 10. CITY OR TOWN OF DEATH<br><u>RANDELSTOWN</u>                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>CHAPEL HILL N.H.</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>HSEWER</u>                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| 13a. STATE <u>MD</u> 13b. COUNTY <u>BALTO</u> 13c. CITY OR TOWN <u>ESSEX</u>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  |                                                                                                                            |                                              |
| 14. FATHER'S NAME<br>FIRST <u>DAY</u> MIDDLE <u>DAY</u> LAST <u>DAY</u>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>UNK</u> MIDDLE <u>UNK</u> LAST <u>UNK</u>                                                                              |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>NO</u>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br><u>UNK</u>                                                                                                                      |  | 17. INFORMANT<br><u>HOWARD MACIVER</u> ADDRESS <u>ABOVE</u>                                                                |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration Bronchopneumonia</u><br><u>5070</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Fracture (old) Jaw</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Chronic Brain Syndrome</u>                                                                                                                                                                                                                                  |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>11</u> <u>20</u> <u>77</u>                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><u>Fall at nursing home.</u>                                              |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>Chapel Hill N.H.</u>                                    |  | 21f. LOCATION<br>STREET <u>Randelstown</u> CITY OR TOWN <u>BALTO.</u> COUNTY <u>MD.</u> STATE                                                               |  |                                                                                                                            |                                              |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7-4-</u> 19 <u>74</u> , to <u>5-21-</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>5-21-</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. <u>Natural</u>                            |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><u>Cesar Valle Caverio</u>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |  | DEGREE<br><u>MD</u>                                                                                                                                         |  | 22c. DATE SIGNED<br><u>5-24-79</u>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>CESAR VALLE CAVERO</u>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                      |  | 22e. ADDRESS<br><u>5310 Old Mt. Rd</u>                                                                                                                      |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><u>5/24/79</u>                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>BALTO. NATL.</u>                                                                                                   |  | 23d. LOCATION<br>CITY OR TOWN <u>BALTO.</u> COUNTY <u>MD.</u> STATE                                                        |                                              |
| 24. FUNERAL DIRECTOR<br>NAME <u>J. G. CONNELLY</u> ADDRESS <u>300 MACE</u>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 31 1979</u>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McCreedy</u>                                                                      |                                              |



1 2 1 2 1





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                        |  | REG. NO. 13742                                                                                         |  |                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                               |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                  |  | LAST                                                                                        |  | 2a DATE OF DEATH MONTH DAY YEAR                                                                                                            |  | 2b HOUR                                      |  |
| ELEANOR                                                                                                                                                                                                                                                                                                                                                                       |  | M.                                                                                                     |  | MAGSAMEN                                                                                                                                                |  |                                                                                             |  | 6 18 79                                                                                                                                    |  | 10:30A                                       |  |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                         |  | 4 RACE                                                                                                 |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                         |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                              |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                                                |  | IF UNDER 72 HRS HOURS MIN.                   |  |
| Female                                                                                                                                                                                                                                                                                                                                                                        |  | White                                                                                                  |  | 12-11-1919                                                                                                                                              |  | 59 YRS.                                                                                     |  |                                                                                                                                            |  |                                              |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                      |  | 7b CITIZEN OF WHAT COUNTRY?                                                                            |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                         |  |                                                                                                                                            |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                      |  | U.S.A.                                                                                                 |  |                                                                                                                                                         |  | BALTO. COUNTY MD.                                                                           |  |                                                                                                                                            |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOW IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
| TOWSON                                                                                                                                                                                                                                                                                                                                                                        |  | GBMC-6701 N. CHARLES ST.                                                                               |  |                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                                                                                                  |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                       |  |                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
| Housewife                                                                                                                                                                                                                                                                                                                                                                     |  | Homemaking                                                                                             |  |                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
| 13a STATE                                                                                                                                                                                                                                                                                                                                                                     |  | 13b COUNTY                                                                                             |  | 13c CITY OR TOWN                                                                                                                                        |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS                                                                                                                         |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                      |  | Harford                                                                                                |  | Forrest Hill                                                                                                                                            |  |                                                                                             |  | 2833 Ady Road                                                                                                                              |  |                                              |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                              |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
| Cosmo Spadaro                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | Rose Dissalvo                                                                                                                                           |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | 16b SOCIAL SECURITY NO.                                                                                                                                 |  | 17 INFORMANT ADDRESS                                                                        |  |                                                                                                                                            |  |                                              |  |
| NO                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | 213-03-9603                                                                                                                                             |  | Leonard J. Magsamen Sr. 2833 Ady Rd.                                                        |  |                                                                                                                                            |  |                                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: flex; justify-content: space-between;"> <div>             DUE TO, OR AS A CONSEQUENCE OF<br/>             (b) METASTATIC BREAST CARCINOMA<br/>             DUE TO, OR AS A CONSEQUENCE OF<br/>             (c)           </div> <div>2 YEARS</div> </div> |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                     |  |                                              |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                          |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                               |  | P.M. 19                                                                                                |  |                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                   |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                            |  |                                              |  |
| 22b. SIGNATURE <i>Te-ching Wang</i>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                         |  | DEGREE                                                                                      |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                             |  |
|                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                            |  | 6-18-79                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                         |  | 22e. ADDRESS                                                                                |  |                                                                                                                                            |  |                                              |  |
| TEH-CHING WANG, M.D.                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                         |  | GBMC-6701 N. CHARLES ST.                                                                    |  |                                                                                                                                            |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                      |  | 23d. LOCATION CITY OR TOWN                                                                  |  | COUNTY                                                                                                                                     |  | STATE                                        |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                        |  | 6-22-79                                                                                                |  | Most Holy Redeemer                                                                                                                                      |  | Balto.,                                                                                     |  |                                                                                                                                            |  | Md.                                          |  |
| 24 FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                         |  | ADDRESS                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |  | 25b. REGISTRAR'S SIGNATURE                   |  |
| LASSAHN FUNERAL HOME                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                         |  | 4001 Belair Road                                                                            |  | JUN 21 1979                                                                                                                                |  | <i>History McCreedy</i>                      |  |

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ELEPHANT - H. HASSANEN

SALTO. COUNTY

TOWSON BEND-7301 .. CHURCH ST.

CARDIOLOGY - ARREST

METASTATIC BREAST CARCINOMA

2 YEARS

6-10-79

YEN-CHING WANG, M.D. BEND-7301 N. CHARLES ST.

SUNSHINE Bldg. 1001 8th

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                                    |  | REG. NO. 13743 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|----------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 1. DECEASED NAME (TYPE OR PRINT)<br><b>Henrietta S. Maize</b>                                                                        |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 15, 1979</b>                                                                                   |  | 2b. HOUR<br><b>8:10 P.M.</b>                                                                                                       |  |                |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>White</b>                                                                                                              |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>MARCH 4 1901</b>                                                                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                                                                          |  | 7. IF UNDER 1 YEAR (MONTHS) DAYS HOURS MIN.                                                                                        |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                        |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, County MD.</b>                                                                       |  |                                                                                                                                    |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Housekeeper</b>                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At home</b>                                                                                |  |                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>BALTO</b>                                                                                                          |  | 13c. CITY OR TOWN<br><b>JACKVILLE</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                               |  | 13e. STREET ADDRESS<br><b>8412 Monkey Drive Apt A</b>                                                                              |  |                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>FRANK DAVIS</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ANNIE OCHRING</b>                                                                   |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                                    |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><b>215-22-0420</b>                                                                                       |  | 17. INFORMANT ADDRESS<br><b>Family Records</b>                                                                                                              |  |                                                                                                                                            |  |                                                                                                                                    |  |                |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute myeloblastic leukemia</b><br>2050<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b> |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                                    |  |                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>acute cholecystitis, arteriosclerotic cardiovascular disease</b>                                                                                                                                                                                                                             |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                                    |  |                |  |
| 19a. DATE OF OPERATION<br><b>6/7</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>cholecystitis</b>                                                             |  |                                                                                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                            |  |                                                                                                                                    |  |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                                            |  |                                                                                                                                    |  |                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 6, 1979</b> to <b>June 15, 1979</b> that (I) (we) last saw the deceased alive on <b>June 15, 1979</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                                                                                               |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                                    |  |                |  |
| 22b. SIGNATURE<br><b>HABERSAT</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | DEGREE                                                                                                                               |  |                                                                                                                                                             |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/16/79</b>                                                                                                 |  |                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HABERSAT</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 22e. ADDRESS<br><b>16918 YORK RD, MONKTON, MD. 21111</b>                                                                             |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                                    |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>6/19/79</b>                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garden of Faith</b>                                                                                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>                                                                                 |  |                                                                                                                                    |  |                |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>EVANS Funeral Chapel</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 24b. ADDRESS<br><b>8800 Hartford Rd</b>                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>                                                                                        |  |                                                                                                                                    |  |                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                      |  |                                                                                                                                                            |                                                                 |                                                                                      |                                |                                                                                                                                       |                                                                                      |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--|
| 1- FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 7 9 1 3 7 4 4                                                                                                                                        |  | REG. NO.                                                                                                                                                   |                                                                 |                                                                                      |                                |                                                                                                                                       |                                                                                      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Edna V. Mae Mann                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                      |  |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 19 1979             |                                                                                      | 2b. HOUR<br>12:15 AM           |                                                                                                                                       |                                                                                      |  |
| 3 SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4 RACE<br>W                                                                                                                                          |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 25 1900                                                                                                            |                                                                 | 6 AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS                                             |                                | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                        |                                                                                      |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                                                  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                 | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                          |                                |                                                                                                                                       |                                                                                      |  |
| 10 CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Medical Center        |  |                                                                                                                                                            |                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK)<br>- Nurse-Sybilist                          |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>- Self                                                                                           |                                                                                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                      |  |                                                                                                                                                            | 13b. COUNTY<br>Baltimore                                        |                                                                                      | 13c. CITY OR TOWN<br>Baltimore |                                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John E. Reichard, Sr.                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                      |  |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Minnie C. Paton |                                                                                      |                                |                                                                                                                                       |                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>214-34-3167-A                                                                                                            |  | 17 INFORMANT<br>ADDRESS<br>Mr. Kenneth L. Mann-727 Overbrook Rd. 12                                                                                        |                                                                 |                                                                                      |                                |                                                                                                                                       |                                                                                      |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia and Pulmonary embolus</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebrovascular Accident</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                                      |  |                                                                                                                                                            |                                                                 |                                                                                      |                                |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                                                            |                                                                 |                                                                                      |                                |                                                                                                                                       |                                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |  |                                                                                                                                                            |                                                                 | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |                                                                 |                                                                                      |                                |                                                                                                                                       |                                                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |                                                                 |                                                                                      |                                |                                                                                                                                       |                                                                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/24</u> , 19 <u>79</u> , to <u>6/19</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/19</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                              |  |                                                                                                                                                      |  |                                                                                                                                                            |                                                                 |                                                                                      |                                |                                                                                                                                       |                                                                                      |  |
| 22b. SIGNATURE<br><i>Charles C. Brown</i>                                                                                                                                                                                                                                                                                                                                                                                                       |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                                                                                            |                                                                 | 22c. DATE SIGNED<br>6/19/79                                                          |                                |                                                                                                                                       |                                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles C. Brown, M.D.                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                      |  | 22e. ADDRESS<br>6701 N. Charles St, Towson, Md. 21204                                                                                                      |                                                                 |                                                                                      |                                |                                                                                                                                       |                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br>6/22/79                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cem.                                                                                                      |                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto City                             |                                |                                                                                                                                       |                                                                                      |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home-6500 York Rd. 21212                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 25 1979                                                                                                               |                                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>Henry McCreedy</i>                                  |                                |                                                                                                                                       |                                                                                      |  |

1011



MINNIE C. TAYLOR

MINNIE C. TAYLOR

MINNIE C. TAYLOR



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 3 7 4 5

REG. NO.

|                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                                                          |  |                                                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                   |  | 2a. DATE OF DEATH                                                                                                                          |  | MONTH DAY YEAR                                                                                                                                           |  | 2b. HOUR                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                         |  | FIRST MIDDLE LAST                                                                                                                          |  | Alice M. Manson                                                                                                                                          |  | June 22 1979                                                        |  |
| 3 SEX                                                                                                                                                                                                                                                                                                                    |  | 4 RACE                                                                                                                                     |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Female                                                                                                                                                                                                                                                                                                                   |  | White                                                                                                                                      |  | MONTH DAY YEAR                                                                                                                                           |  | 95 YRS.                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Maryland                                                                                                                                                                                                                                                                                                                 |  | USA                                                                                                                                        |  |                                                                                                                                                          |  | Baltimore County MD.                                                |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Dundalk                                                                                                                                                                                                                                                                                                                  |  | 135 Bayside Drive                                                                                                                          |  | Housewife                                                                                                                                                |  |                                                                     |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                                                                |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  |
| Md                                                                                                                                                                                                                                                                                                                       |  | Baltimore                                                                                                                                  |  | Dundalk                                                                                                                                                  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                                                                                                   |  | 13e. STREET ADDRESS                                                                                                                                      |  |                                                                     |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                        |  | FIRST MIDDLE LAST                                                                                                                          |  | 135 Bayside Drive 21222                                                                                                                                  |  |                                                                     |  |
| James T. Kenny                                                                                                                                                                                                                                                                                                           |  | Margaret Carrigan                                                                                                                          |  |                                                                                                                                                          |  |                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                                   |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                             |  |
| No                                                                                                                                                                                                                                                                                                                       |  | 212-48-2625                                                                                                                                |  | Mr. John E. Manson                                                                                                                                       |  | 135 Bayside Drive                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)                                                                                                                                                                                                |  | 410 - Prob. Myocardial Infarction                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  | Four                                                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                            |  | DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                         |  | ASCVD                                                                                                                                                    |  |                                                                     |  |
|                                                                                                                                                                                                                                                                                                                          |  | DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                         |  |                                                                                                                                                          |  |                                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                      |  |                                                                                                                                            |  |                                                                                                                                                          |  |                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                       |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                                                                           |  |                                                                     |  |
|                                                                                                                                                                                                                                                                                                                          |  | P.M. 19                                                                                                                                    |  |                                                                                                                                                          |  |                                                                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |  |
|                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                                                          |  |                                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                            |  |                                                                                                                                                          |  |                                                                     |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                           |  | DEGREE                                                                                                                                     |  | 22c. DATE SIGNED                                                                                                                                         |  |                                                                     |  |
| Dr. Rene P. De Los Santos                                                                                                                                                                                                                                                                                                |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                                                                                          |  |                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                    |  | 22e. ADDRESS                                                                                                                               |  |                                                                                                                                                          |  |                                                                     |  |
| Dr. Rene P. De Los Santos                                                                                                                                                                                                                                                                                                |  |                                                                                                                                            |  |                                                                                                                                                          |  |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                |  | 23b. DATE                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| Burial                                                                                                                                                                                                                                                                                                                   |  | 6/25/79                                                                                                                                    |  | New Cathedral                                                                                                                                            |  | Baltimore Maryland                                                  |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                |  | 24b. ADDRESS                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                          |  |
| Duda-Ruck Funeral Home                                                                                                                                                                                                                                                                                                   |  | 7922 Wise Ave Dundalk of Dundalk, Inc                                                                                                      |  | 21222 JUN 26 1979                                                                                                                                        |  | Ruthy Reddy                                                         |  |

100-100000

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

DATE: 10-10-60

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

RE: [illegible]

DATE: 10-10-60

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

RE: [illegible]

DATE: 10-10-60

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

RE: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                          |  | REG. NO. 79 13746                                                                                                                  |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Nicola MARROCCO                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>6 22 79                                                                                                                 |  | 2b. HOUR a<br>11:00 M                                                                |  |                                                                                                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>White                                                                                                                   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 27, 1893                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.                                           |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Construction        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |  | 13b. COUNTY<br>Baltimore                                                                                                                                    |  | 13c. CITY OR TOWN<br>Sweet Air                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Franco                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARIA Giuseppina Raspa                                                                                        |  | 13e. STREET ADDRESS<br>Sweet Air, Md 21131<br>4005 Eland Road                        |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>212-10-7095                                                                                            |  | 17. INFORMANT Son: Joseph Marrocco                                                                                                                          |  | ADDRESS Sweet Air, Md 21131<br>3905 Eland Road                                       |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Cardiac Arrest<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/20/ 19 79, to 6/22/ 19 79, that (I) (we) lost saw the deceased alive on 6/22/ 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                              |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Michael Koger M.D.                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>6/22/79                                                          |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael Koger, M.D.                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  | 22e. ADDRESS<br>9000 Franklin Square Drive                                                                                                                  |  |                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br>Jun 26 1979                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer                                                                                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                        |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR NAME<br>Leonard J. Ruck, Inc.                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |  | ADDRESS<br>Baltimore, Maryland                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 26 1979                                         |  | 25b. REGISTRAR'S SIGNATURE<br>Bridget McCreedy                                                                             |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |                                                                               |                                                                                                                                                            |                                                                                    |                                                                                      |                                                                                                                                                                        |                                                                                                                            |                                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      | 7 9 1 3 7 4 7<br>REG. NO.                                                     |                                                                                                                                                            |                                                                                    |                                                                                      |                                                                                                                                                                        |                                                                                                                            |                                                  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Milton Irving Martin</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 1, 1979</b>                    |                                                                                                                                                            |                                                                                    | 2b. HOUR<br><b>11 p.m.</b>                                                           |                                                                                                                                                                        |                                                                                                                            |                                                  |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4 RACE<br><b>White</b>                                                                                                               |                                                                               | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 18, 1899</b>                                                                                                 |                                                                                    | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80 yrs.</b>                                     |                                                                                                                                                                        | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                        |                                                                               | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                   |                                                                                                                                                                        |                                                                                                                            |                                                  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Pikesville</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>113 Waldren Ave.</b> |                                                                               |                                                                                                                                                            |                                                                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b> |                                                                                                                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>                                                                   |                                                  |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      | 13b. COUNTY<br><b>Balto.</b>                                                  |                                                                                                                                                            | 13c. CITY OR TOWN<br><b>Pikesville</b>                                             |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                                                                                                            | 13e. STREET ADDRESS<br><b>113 Waldren Ave.</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harvey T. Martin</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |                                                                               |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Emma Baublitz</b>         |                                                                                      |                                                                                                                                                                        |                                                                                                                            |                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-12-2662</b> |                                                                                                                                                            | 17. INFORMANT<br>ADDRESS<br><b>Rachel Martin 113 Waldren Ave., Pikesville, Md.</b> |                                                                                      |                                                                                                                                                                        |                                                                                                                            |                                                  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Regal Carcinoma with liver metastases</b><br>1541<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>18 months</b> |  |                                                                                                                                      |                                                                               |                                                                                                                                                            |                                                                                    |                                                                                      |                                                                                                                                                                        |                                                                                                                            |                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Arteriosclerotic heart disease with chronic atrial fibrillation</b>                                                                                                                                                                                                                                  |  |                                                                                                                                      |                                                                               |                                                                                                                                                            |                                                                                    |                                                                                      |                                                                                                                                                                        |                                                                                                                            |                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |                                                                                                                                                            |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                                                                                                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |                                                                                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |                                                                                      |                                                                                                                                                                        |                                                                                                                            |                                                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |                                                                                                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |                                                                                      |                                                                                                                                                                        |                                                                                                                            |                                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/28, 1974</b> , to <b>6/1, 1979</b> , that (I) (we) lost saw the deceased alive on <b>5/16, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.                                                                                                           |  |                                                                                                                                      |                                                                               |                                                                                                                                                            |                                                                                    |                                                                                      |                                                                                                                                                                        |                                                                                                                            |                                                  |  |
| 22b. SIGNATURE<br><b>H. Ronald Friedman MD</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |                                                                               |                                                                                                                                                            | DEGREE                                                                             |                                                                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                                                                                                                            | 22c. DATE SIGNED                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. Ronald Friedman</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |                                                                               |                                                                                                                                                            | 22e. ADDRESS<br><b>6715 Park Heights Ave.</b>                                      |                                                                                      |                                                                                                                                                                        |                                                                                                                            |                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      | 23b. DATE<br><b>June 4, 1979</b>                                              |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grace Church Cemetery</b>                 |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Upperco Md.</b>                                                                                                       |                                                                                                                            |                                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>H. F. Schmitt</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |                                                                               |                                                                                                                                                            | ADDRESS<br><b>Owings Mills, Md.</b>                                                |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1979</b>                                                                                                                     |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>R. H. Brady</b> |  |

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208-55-81-28



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 13748

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                           |                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARTHA E MASON</b>                                                                                                                                                                                                                                                                                 |                                                                                                                                               |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 22, 1979</b>                                        |                                                                                           | 2b. HOUR<br><b>9:50 A.M.</b>      |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><b>White</b>                                                                                                                       | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 8, 1878</b>                                                                                                     |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>101</b> YRS                                         |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                       |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Randallstown Conv. Center</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nursing Companion</b>    |                                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                             |                                                                                                                                               | 13b. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>2011 Kernan Drive 21207</b>                                     |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Julius Klischies</b>                                                                                                                                                                                                                                                                         |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna G. (Unknown)</b>                                                                                   |                                                                                                 |                                                                                           |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                         |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>none</b>                                                                                      |                                                                                                 | 17. INFORMANT<br><b>Mrs. Rose E. Hudgins</b><br><b>2011 Kernan Drive Balto. Md. 21207</b> |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCU</b><br>410-                                               |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                           |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>FX Hip 1978</b>                                                                                                                                                                                |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                           |                                   |
| 19a. DATE OF OPERATION<br><b>7/1/78</b>                                                                                                                                                                                                                                                                                                   |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Kip</b>                                                                                              |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                |                                                                                                                                               | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |                                                                                                 |                                                                                           |                                   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                                                                                                                                                                                                              |                                                                                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                 |                                                                                           |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                 |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                         |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1978</b> , 19____, to <b>6/22/79</b> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                           |                                   |
| 22b. SIGNATURE<br><b>W. L. F. SON</b>                                                                                                                                                                                                                                                                                                     |                                                                                                                                               | DEGREE<br><b>W. L. F. SON</b>                                                                                                                               |                                                                                                 | 22c. DATE SIGNED<br><b>6/22/79</b>                                                        |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. L. F. SON</b>                                                                                                                                                                                                                                                                              |                                                                                                                                               | 22e. ADDRESS<br><b>3502 W. Rogers</b>                                                                                                                       |                                                                                                 |                                                                                           |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                |                                                                                                                                               | 23b. DATE<br><b>June 25, 79</b>                                                                                                                             |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Magothy Method. Ch. Cem.</b>                     |                                   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Jacobsville</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                               | 23e. STATE<br><b>Anne Md.</b>                                                                                                                               |                                                                                                 | 23f. COUNTY<br><b>Amundel</b>                                                             |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, P.A.</b>                                                                                                                                                                                                                                                               |                                                                                                                                               | ADDRESS<br><b>8728 Liberty Road Randallstown, Md. 21133</b>                                                                                                 |                                                                                                 | 25. DATE REC'D. BY REGISTRAR<br><b>JUN 28 1979</b>                                        |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey K. Brady</b>                                                                                                                                                                                                                                                                                     |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                           |                                   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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unpublished information  
concerning military service

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                               |                                                                                |                                                          |                                                                                                                            |                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                      |  | 7 9 1 3 7 4 9<br>REG. NO.                                                                                                       |                                                                     |                                                                                                                                                             |                                                               |                                                                                |                                                          |                                                                                                                            |                                                                                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>August O Mattern                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 15 1979              |                                                                                |                                                          | 2b. HOUR<br>11 1/2 PM                                                                                                      |                                                                                                 |  |
| 3 SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                               |  | 4 RACE<br>White                                                                                                                 |                                                                     | 5 DATE OF BIRTH MONTH DAY YEAR<br>3 1 05                                                                                                                    |                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                     |                                                          | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |                                                          |                                                                                                                            |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mancor Care Rossville |                                                                     |                                                                                                                                                             |                                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Foreman       |                                                          | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel Mfrg.                                                                           |                                                                                                 |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | 13b. COUNTY<br>Balto.                                         |                                                                                | 13c. CITY OR TOWN<br>Dundalk                             |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>August O Mattern Sr.                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Bessie J Miller |                                                                                |                                                          |                                                                                                                            |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>212-05-7629                       |                                                                                | 17 INFORMANT ADDRESS<br>Charles W. Mattern--Same as 13e  |                                                                                                                            |                                                                                                 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>5990<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Septicemia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Urinary tract infection</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                               |                                                                                |                                                          |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Cerebral infarction (old)</u>                                                                                                                                                                                                                                     |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                               |                                                                                |                                                          |                                                                                                                            |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                             |                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                       |  |                                                                                                                                 | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                          |                                                                                                                            |                                                                                                 |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                               | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                          |                                                                                                                            |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/9 19 79, to 6/15 19 79, that (I) (we) last saw the deceased alive on 6/14 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                                                                                    |  |                                                                                                                                 |                                                                     |                                                                                                                                                             |                                                               |                                                                                |                                                          |                                                                                                                            |                                                                                                 |  |
| 22b. SIGNATURE<br>N. Haroun                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | DEGREE<br>M.D.                                                |                                                                                |                                                          | 22c. DATE SIGNED<br>6/16/79                                                                                                |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NAJJI JOSEPH HAROUN                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | 22e. ADDRESS<br>9101 Franklin Square Dr., Balto. 21237        |                                                                                |                                                          |                                                                                                                            |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                 | 23b. DATE<br>6/18/1979                                              |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery       |                                                                                | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md. |                                                                                                                            |                                                                                                 |  |
| 24. FUNERAL DIRECTOR NAME<br>Walter Brooks Bradley Inc.                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | ADDRESS<br>Balto., Md.                                        |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br>JUN 18 1979             |                                                                                                                            |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                 |                                                                     |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreedy                |                                                                                |                                                          |                                                                                                                            |                                                                                                 |  |

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RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI (100-441111) FROM : SAC, NEW YORK (100-111111)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

100-111111-1111

[Illegible]

[Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                              |  |                                                                                                                                |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                               |  | 7 9 1 3 7 5 0<br>REG. NO.                       |  |                     |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|---------------------|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                      |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                            |  | FIRST<br>Sarah                                                                                                                                             |  | MIDDLE<br>A.                                                                                    |  | LAST<br>McAlister                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6/7/79   |  | 2b. HOUR<br>2:57 PM |  |  |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                   |  | 4 RACE<br>White                                                                                                                |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>May 28, 1883                                                                                                          |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>96 YRS.                                                       |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                              |  | 8 IF UNDER 24 HRS<br>HOURS MIN.                 |  |                     |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wilmington, Del.                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>-U.S.A.                                                                                        |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                     |  |                                                                                                                               |  |                                                 |  |                     |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH PLACE, GIVE HOME ADDRESS)<br>Marian Carey Rd. 21204 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaker                                                  |  |                                                                                                                               |  |                                                 |  |                     |  |  |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br>-----                                                                                                           |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3 N. Highland Avenue                                                                                   |  |                                                 |  |                     |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>? ? Kyle                                                                                                                                                                                                                                                                                 |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>? ? Hart                                                                       |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                               |  |                                                 |  |                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>??                                                                  |  | 17 INFORMANT<br>Towson, Md. 21204.<br>J. Norris Byrnes-305 W. Penn. Avenue                                                                                 |  |                                                                                                 |  |                                                                                                                               |  |                                                 |  |                     |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) 436- Progressive CVA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                 |  |                                                                                                                                |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                               |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                     |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                |  |                                                                                                                                |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                               |  |                                                 |  |                     |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |  |                                                                                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                 |  |                     |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                             |  |                                                                                                 |  |                                                                                                                               |  |                                                 |  |                     |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                                 |  |                                                                                                                               |  |                                                 |  |                     |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                               |  |                                                 |  |                     |  |  |  |
| 22b. SIGNATURE<br>Joel S. Kleinman, M.D.                                                                                                                                                                                                                                                                                          |  | 22c. DATE SIGNED                                                                                                               |  | 22d. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |  |                                                                                                 |  |                                                                                                                               |  |                                                 |  |                     |  |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joel S. Kleinman, M.D.                                                                                                                                                                                                                                                                   |  | 22f. ADDRESS<br>9712 Belair Rd. Balto., Md.                                                                                    |  |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                               |  |                                                 |  |                     |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                            |  | 23b. DATE<br>6/11/79                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Baltimore Maryland                      |  |                                                                                                                               |  |                                                 |  |                     |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>John H. Moran, Inc.                                                                                                                                                                                                                                                                                |  | 24b. ADDRESS<br>3000 E. Baltimore St.<br>Baltimore MD 21204                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 12 1979                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McCready                                                  |  |                                                                                                                               |  |                                                 |  |                     |  |  |  |

18120



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                                                                                            |                                                                               |                                                                                                                            |                                                                    |                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                 |  |                                                                                                                                                             | 79 13751<br>REG. NO.                                                                                                                       |                                                                               |                                                                                                                            |                                                                    |                                                                                                 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Hilda Elizabeth McCray                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                 |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 13, 1979                                                                                       |                                                                               |                                                                                                                            | 2b. HOUR<br>7:00 M                                                 |                                                                                                 |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>White                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10/22/1912                                                                                                            |                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS                                     |                                                                                                                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                                                                                 |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Ohio                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |                                                                                                                            |                                                                    |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7729 Fairgreen Rd. |  |                                                                                                                                                             |                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                  |                                                                                                 |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 |  |                                                                                                                                                             | 13b. COUNTY<br>Balto.                                                                                                                      |                                                                               | 13c. CITY OR TOWN<br>Dundalk                                                                                               |                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William McDonald                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Selby                                                                                |                                                                               |                                                                                                                            |                                                                    |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>269.10.7455                                                          |  | 17. INFORMANT<br>ADDRESS<br>Elsie A. Hood--Same as 13e                                                                                                      |                                                                                                                                            |                                                                               |                                                                                                                            |                                                                    |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetes mellitus</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                                                                                            |                                                                               |                                                                                                                            |                                                                    |                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                         |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                                                                                            |                                                                               |                                                                                                                            |                                                                    |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                    |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                                                            |                                                                               |                                                                                                                            |                                                                    |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                                            |                                                                               |                                                                                                                            |                                                                    |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-29</u> , 19 <u>75</u> , to <u>5/23</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5/23/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |                                                                                                                                 |  |                                                                                                                                                             |                                                                                                                                            |                                                                               |                                                                                                                            |                                                                    |                                                                                                 |  |
| 22b. SIGNATURE<br><u>Marcos Levin</u> DEGREE <u>MD</u>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 |  |                                                                                                                                                             | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                               |                                                                                                                            | 22c. DATE SIGNED<br>6/13/1979                                      |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marcos Levin, M.D.                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                 |  |                                                                                                                                                             | 22e. ADDRESS<br>201 Wise Ave., Dundalk, Md. 21222                                                                                          |                                                                               |                                                                                                                            |                                                                    |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br>6/16/1979                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.                                                                                                  |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Maryland               |                                                                                                                            |                                                                    |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Brooks Bradley Inc. Dundalk, Md.                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                 |  |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 15 1979                                                                                               |                                                                               | 25b. REGISTRAR'S SIGNATURE<br><u>Patrick McCready</u>                                                                      |                                                                    |                                                                                                 |  |

MEDICAL CERTIFICATION

13121







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

1 3 7 5 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                           |                                                                                                                                                      |                                                                 |                                                                                                                                          |                                                                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BABY BOY McDOWELL</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6/18/79</b>                  |                                                                                                                                                             |                                                                           | 2b. HOUR<br><b>9:10 aM</b>                                                                                                                           |                                                                 |                                                                                                                                          |                                                                                                 |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>Caucasian</b>                                                                                                                          |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6/17/79</b>                                                                                                        |                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS<br><b>10</b>                                                                                          |                                                                 | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.<br><b>10</b>                                                                         |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                        |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                                                  |                                                                 |                                                                                                                                          |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |                                                                        |                                                                                                                                                             |                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>                                                                      |                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>                                                                                          |                                                                                                 |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             | 13b. COUNTY<br><b>BALTO.</b>                                              |                                                                                                                                                      | 13c. CITY OR TOWN<br><b>EDGEHIRE</b>                            |                                                                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Joseph McDowell</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice Marie Ewing</b> |                                                                                                                                                      |                                                                 |                                                                                                                                          |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>                                |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Mr. Wm. J. McDowell 2620 Brannan Ave.</b>  |                                                                                                                                                      |                                                                 |                                                                                                                                          |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>7708</b> IMMEDIATE CAUSE (a) <b>Intraventricular hemorrhages</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Respiratory insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Prematurity</b>                                                       |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                           |                                                                                                                                                      |                                                                 |                                                                                                                                          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                         |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                           |                                                                                                                                                      |                                                                 |                                                                                                                                          |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                           | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                 |                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |  |                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                           | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                    |                                                                 |                                                                                                                                          |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                |  |                                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                 |                                                                                                                                          |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/17</b> , 19 <b>79</b> , to <b>6/18</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/18/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                           |                                                                                                                                                      |                                                                 |                                                                                                                                          |                                                                                                 |  |
| 22b. SIGNATURE<br><b>Charles C. Brown</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                           | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                 | 22c. DATE SIGNED<br><b>6/18/79</b>                                                                                                       |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles C. Brown, M.D.</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                           | 22e. ADDRESS<br><b>6701 N. Charles St., Balto., MD 21204</b>                                                                                         |                                                                 |                                                                                                                                          |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                      | 23b. DATE<br><b>6-20-79</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hills Cemetery</b>         |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |                                                                                                                                          |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Harshy Miller 7527 Nayford Rd.</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                           | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 21 1979</b>                                                                                                  |                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>                                                                                    |                                                                                                 |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |                                                                                |                                                                                                                                                             |                                                            |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Paul A. Mc Gee                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 13, 1979                           |                                                                                                                                                             |                                                            | 2b. HOUR<br>M                                                                                                                              |                                                                                                 |                                                                                                                            |                                          |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                     |  | 4 RACE<br>White                                                                                                                |                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 23, 1904                                                                                                        |                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75<br>YRS.                                                                                              |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                       |                                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                               |                                                                                                 |                                                                                                                            |                                          |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>67 Northship Road |                                                                                |                                                                                                                                                             |                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Heater                                                                 |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel Industry                                                                        |                                          |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                | 13b. COUNTY<br>Baltimore                                                       |                                                                                                                                                             | 13c. CITY OR TOWN<br>Dundalk                               |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br>67 Northship Road |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Patrick Mc Gee                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                |                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes UNKNOWN                                                                                              |                                                            |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-07-1345         |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>Winnie D. Mc Gee, Same As #13e |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                          |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>heart failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of rectum</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>with liver metastases</i><br>1541<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                |                                                                                |                                                                                                                                                             |                                                            |                                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 yr.                                                                      |                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                               |  |                                                                                                                                |                                                                                |                                                                                                                                                             |                                                            |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Carcinoma of rectum</i> |                                                                                                                                                             |                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                          |  |                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                     |                                                                                                                                                             |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                 |                                                                                                                            |                                          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |                                                                                                                                                             |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                 |                                                                                                                            |                                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.                                                                                |  |                                                                                                                                |                                                                                |                                                                                                                                                             |                                                            |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                          |  |
| 22b. SIGNATURE<br><i>Samuel D. Gaby</i><br>DEGREE                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                |                                                                                |                                                                                                                                                             |                                                            | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br>6/15/79                                                                                                |                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Samuel D. Gaby M.D.                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                |                                                                                |                                                                                                                                                             |                                                            | 22e. ADDRESS<br>19 Walker Ave, Pikesville, Maryland                                                                                        |                                                                                                 |                                                                                                                            |                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                | 23b. DATE<br>6-16-79                                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Oaklawn Cemetery     |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |                                                                                                                            |                                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck Funeral Home, Inc. 7922 Wise Ave.                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                |                                                                                |                                                                                                                                                             |                                                            | 25a. DATE RECEIVED BY REGISTRAR<br>JUN 19 1979                                                                                             |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>Robert H. Brady</i>                                                                       |                                          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                       |                                                                                   | REG. NO. 13754                                                                              |                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME (TYPE OR PRINT)<br><b>George Joseph McKeever</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | 2a DATE OF DEATH MONTH DAY YEAR<br><b>June 8, 1979</b>                                                                                                     |                                                                                   | 2b HOUR p<br><b>6:10 M</b>                                                                  |                                                                                                                         |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 4 RACE<br><b>White</b>                                                                                                               | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>6 28 1906</b>                                                                                                         |                                                                                   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS                                             |                                                                                                                         |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.a</b>                                                                                          | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                          |                                                                                                                         |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |                                                                                                                                                            | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>accountant</b> |                                                                                             | 12b KIND OF BUSINESS OR INDUSTRY<br><b>oil</b>                                                                          |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      | 13b COUNTY<br><b>Balto.</b>                                                                                                                                | 13c CITY OR TOWN<br><b>Cockeysville</b>                                           | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                         |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>John Thomas McKeever</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br><b>Margaret Sommeth</b>                                                                                           |                                                                                   |                                                                                             |                                                                                                                         |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                      | 16b SOCIAL SECURITY NO.<br><b>215-05-8835A</b>                                                                                                             |                                                                                   | 17 INFORMANT ADDRESS<br><b>Elizabeth McKeever 10321 Malcolm Circle</b>                      |                                                                                                                         |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Brain Tumor</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                      |                                                                                                                                                            |                                                                                   |                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |
| 2396<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      |                                                                                                                                                            |                                                                                   |                                                                                             |                                                                                                                         |
| DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      |                                                                                                                                                            |                                                                                   |                                                                                             |                                                                                                                         |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      |                                                                                                                                                            |                                                                                   |                                                                                             |                                                                                                                         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      |                                                                                                                                                            |                                                                                   |                                                                                             |                                                                                                                         |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                      | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                   | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                             |                                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |                                                                                                                         |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                        |                                                                                   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                              |                                                                                                                         |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 12, 1979</b> to <b>June 8, 1979</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>June 8, 1979</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death. |                                                                                                                                      |                                                                                                                                                            |                                                                                   |                                                                                             |                                                                                                                         |
| 22b. SIGNATURE<br><i>Neatley P. Dizon</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                      | DEGREE<br><b>M.D.</b>                                                                                                                                      |                                                                                   | 22c. DATE SIGNED<br><b>June 8, 1979</b>                                                     |                                                                                                                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. E. Lowell Lemmon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                      | 22e. ADDRESS<br><b>10 W. Padonia Rd.</b>                                                                                                                   |                                                                                   |                                                                                             |                                                                                                                         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                      | 23b. DATE<br><b>6/12/79</b>                                                                                                                                |                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                                 |                                                                                                                         |
| 23d. LOCATION CITY OR TOWN<br><b>Cockeysville</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      | COUNTY<br><b>Balto.</b>                                                                                                                                    |                                                                                   | STATE<br><b>Md.</b>                                                                         |                                                                                                                         |
| 24. FUNERAL DIRECTOR<br><i>J. E. Lowell Lemmon</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      | ADDRESS<br><b>10 W. Padonia Rd.</b>                                                                                                                        |                                                                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1979</b>                                         |                                                                                                                         |
| 25b. REGISTRAR'S SIGNATURE<br><i>Robert H. H. H.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                            |                                                                                   |                                                                                             |                                                                                                                         |

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George Jackson Wolkover June 8, 1972

John Wolkover June 8, 1972

U.S. Baltimore County

Township St. Joseph Hospital

John Wolkover June 8, 1972

John Wolkover June 8, 1972

John Wolkover June 8, 1972

Train Track

John Wolkover June 8, 1972

John Wolkover June 8, 1972

John Wolkover June 8, 1972

John Wolkover June 8, 1972



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13755

|                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                     |  |                                                                                                                                  |  |                   |  |                                                                                                                                                             |  |                                               |  |                                                                                                 |  |                           |  |                                    |  |                                                                                     |  |           |  |              |  |                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|-------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|---------------------------|--|------------------------------------|--|-------------------------------------------------------------------------------------|--|-----------|--|--------------|--|--------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                |  | 2. DECEASED NAME<br>(TYPE OR PRINT) |  | FIRST<br>WILLIAM                                                                                                                 |  | MIDDLE<br>STANLEY |  | LAST<br>MCNEIL                                                                                                                                              |  | 7a. DATE KNOWN OF DEATH<br>ESTIMATED          |  | MONTH<br>6                                                                                      |  | DAY<br>20                 |  | YEAR<br>1979                       |  | 7b. HOUR<br>6:10<br>A.M.                                                            |  |           |  |              |  |                          |  |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>white                    |  | 5. DATE OF BIRTH<br>MONTH<br>4                                                                                                   |  | DAY<br>9          |  | YEAR<br>52                                                                                                                                                  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>27 YRS. |  | IF UNDER 1 YR.<br>MONTHS                                                                        |  | IF UNDER 24 HRS.<br>HOURS |  | MIN.                               |  | 7c. DATE PRONOUNCED DEAD<br>MONTH<br>6                                              |  | DAY<br>20 |  | YEAR<br>1979 |  | 7d. HOUR<br>6:10<br>A.M. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA                                                                                                                                                                                                                                                                                                                                                                                 |  |                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA.                                                                                             |  |                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County                                        |  |                           |  |                                    |  |                                                                                     |  | MD.       |  |              |  |                          |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8315 Stansbury Rd. |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNEMP.                                                                                     |  |                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |                           |  |                                    |  |                                                                                     |  |           |  |              |  |                          |  |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                     |  | 13b. COUNTY<br>BALTO.                                                                                                            |  |                   |  | 13c. CITY OR TOWN<br>ESSEX                                                                                                                                  |  |                                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                           |  | 13e. STREET ADDRESS<br>323 WYE RD. |  |                                                                                     |  |           |  |              |  |                          |  |
| 14. FATHER'S NAME<br>FIRST<br>CECIL                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                     |  | MIDDLE<br>MCNEIL                                                                                                                 |  |                   |  | LAST<br>TERRY                                                                                                                                               |  |                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>THELMA                                                     |  |                           |  | MIDDLE<br>TERRY                    |  |                                                                                     |  | LAST      |  |              |  |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES                                                                                                                                                                                                                                                                                                                                                          |  |                                     |  | (IF YES, GIVE WAR OR DATES)<br>WW II                                                                                             |  |                   |  | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  |                                               |  | 17. INFORMANT<br>PARENTS                                                                        |  |                           |  | ADDRESS<br>ABOVE                   |  |                                                                                     |  |           |  |              |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: Multiple injuries<br>IMMEDIATE CAUSE (a) 9688<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                              |  |                                     |  |                                                                                                                                  |  |                   |  |                                                                                                                                                             |  |                                               |  |                                                                                                 |  |                           |  |                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |           |  |              |  |                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                        |  |                                     |  |                                                                                                                                  |  |                   |  |                                                                                                                                                             |  |                                               |  |                                                                                                 |  |                           |  |                                    |  |                                                                                     |  |           |  |              |  |                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                |  |                   |  |                                                                                                                                                             |  |                                               |  |                                                                                                 |  |                           |  |                                    |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |           |  |              |  |                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                        |  |                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>2:40AM 6 20 79                                                                |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject was beaten                                                         |  |                                               |  |                                                                                                 |  |                           |  |                                    |  |                                                                                     |  |           |  |              |  |                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                             |  |                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street                                                            |  |                   |  | 21f. LOCATION<br>8315 Stansbury Road OR TOWN Baltimore, Md. STATE                                                                                           |  |                                               |  |                                                                                                 |  |                           |  |                                    |  |                                                                                     |  |           |  |              |  |                          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                     |  |                                                                                                                                  |  |                   |  |                                                                                                                                                             |  |                                               |  |                                                                                                 |  |                           |  |                                    |  |                                                                                     |  |           |  |              |  |                          |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell                                                                                                                                                                                                                                                                                                                                                                                               |  |                                     |  | TITLE (SPECIFY)<br>M.D. Assistant                                                                                                |  |                   |  | MEDICAL EXAMINER                                                                                                                                            |  |                                               |  | DATE SIGNED<br>6/20/79                                                                          |  |                           |  |                                    |  |                                                                                     |  |           |  |              |  |                          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                       |  |                                     |  | ADDRESS<br>111 Penn Street                                                                                                       |  |                   |  |                                                                                                                                                             |  |                                               |  |                                                                                                 |  |                           |  |                                    |  |                                                                                     |  |           |  |              |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                |  |                                     |  | 23b. DATE<br>6/23/79                                                                                                             |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLLY HILL                                                                                                            |  |                                               |  | 23d. LOCATION<br>CITY OR TOWN<br>MIDDLE RIVER BALTO MD.                                         |  |                           |  | STATE                              |  |                                                                                     |  |           |  |              |  |                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>CONNELLY F.H.                                                                                                                                                                                                                                                                                                                                                                                         |  |                                     |  | ADDRESS<br>300 MACE AVE.                                                                                                         |  |                   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 26 1979                                                                                                                |  |                                               |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCready                                                  |  |                           |  |                                    |  |                                                                                     |  |           |  |              |  |                          |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |                                                                          |                                                                                |                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | 7 9 1 3 / 5 6                                                                                                                                               |                                                                          | 1. REG. NO.                                                                    |                                                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             | 2a. DATE OF DEATH                                                        |                                                                                | 2b. HOUR                                                          |
| Minna W. MCQUAY                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             | June 29, 1979                                                            |                                                                                | 8:30P M                                                           |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)                                          |                                                                                | IF UNDER 1 YEAR                                                   |
| Female                                                                                                                                                                                                                                                                                                                                                                                                | White                                                                                                     | MONTH 8 DAY 25 YEAR 1891                                                                                                                                    | 87 YRS                                                                   |                                                                                | IF UNDER 24 HRS                                                   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)                                                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                     |                                                                                |                                                                   |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                              | USA                                                                                                       |                                                                                                                                                             | Baltimore County MD.                                                     |                                                                                |                                                                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)         |                                                                                | 12b. KIND OF BUSINESS OR<br>INDUSTRY                              |
| Rossville                                                                                                                                                                                                                                                                                                                                                                                             | Franklin Square Hospital                                                                                  |                                                                                                                                                             | Housewife                                                                |                                                                                | Homemaking                                                        |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             | 13b. INSIDE CITY LIMITS?                                                 |                                                                                | 13c. STREET ADDRESS                                               |
| 13a. STATE Maryland                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             | 13b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                | 9108 Deborah Avenue                                               |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME                                                 |                                                                                |                                                                   |
| FIRST MIDDLE LAST<br>Conrad Wagner                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             | FIRST MIDDLE LAST<br>Catherine Weissing                                  |                                                                                |                                                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 16b. SOCIAL SECURITY NO.                                                                                                                                    | 17. INFORMANT ADDRESS                                                    |                                                                                |                                                                   |
| No                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           | 217-03-6669D                                                                                                                                                | Ruth Walkemeyer 9108 Deborah Ave.                                        |                                                                                |                                                                   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest<br>4292 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which } (b) Arteriosclerotic cardiovascular disease<br>gave rise to immediate }<br>cause (a), stating the }<br>underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                           |                                                                                                                                                             |                                                                          |                                                                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             |                                                                          |                                                                                |                                                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                          | 20a. AUTOPSY?                                                                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |
|                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |                                                                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | YES <input type="checkbox"/> NO <input type="checkbox"/>          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                              |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                          |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                   |
| 22a. I certify that (X) (this hospital) attended the deceased from June 28, 19 79, to June 29, 19 79, that (X) (we) lost<br>saw the deceased alive on June 29, 19 79, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (X) (we) (did) (did not) view the body after death.                                                                      |                                                                                                           |                                                                                                                                                             |                                                                          |                                                                                |                                                                   |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | DEGREE                                                                                                                                                      |                                                                          | 22c. DATE SIGNED                                                               |                                                                   |
| Rose Gomez MD                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                                                          | 6/29/79                                                                        |                                                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 22e. ADDRESS                                                                                                                                                |                                                                          |                                                                                |                                                                   |
| Rose Gomez MD                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | 9000 Franklin Square Dr. 21237                                                                                                                              |                                                                          |                                                                                |                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | 23b. DATE                                                                                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY                                       |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                        |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | 7/2/79                                                                                                                                                      | Parkwood Cemetery Parkville                                              |                                                                                | Baltimore Md.                                                     |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | ADDRESS                                                                                                                                                     |                                                                          | 25a. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE                        |                                                                   |
| Lassahn Funeral Home                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 7401 Belair Road                                                                                                                                            |                                                                          | JUL 6 1979                                                                     |                                                                   |

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Items #10a-22a Film 0533 7/24/79 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13757

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                          |                                                                                                                                               |                                                                                                                                           |                                                                                                                                                             |                                                                                     |                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Bonnie C. Meilhammer</b>                                                                                                                                                                                                                                                                                                                                                                     |                          |                                                                                                                                               | 2b. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/><br>MONTH DAY YEAR<br><b>6 6 19 79</b> |                                                                                                                                                             |                                                                                     | 2d. HOUR<br>M<br><b>2:25 P.M.</b>                                    |
| 3. SEX<br><b>White</b>                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><b>Female</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV 8 50</b>                                                                                         | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br><b>28</b> YRS.                                                                                      | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                    | IF UNDER 24 HRS.                                                                    | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>6 6 19 79</b>       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                 |                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |                                                                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County,</b> MD. |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>                                                                                                                                                                                                                                                                                                                                                                                              |                          | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |                                                                                                                                           |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>        |                                                                      |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                          | 13b. COUNTY<br><b>BALTO</b>                                                                                                                   | 13c. CITY OR TOWN<br><b>ESSEX</b>                                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        | 13e. STREET ADDRESS<br><b>301 APT 2B FARWIND</b>                                    |                                                                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN MEILHAMMER</b>                                                                                                                                                                                                                                                                                                                                                                       |                          |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>PHYLLIS ME COY</b>                                                                    |                                                                                                                                                             |                                                                                     |                                                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                     |                          | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-58-6540</b>                                                                 |                                                                                                                                           | 17. INFORMANT ADDRESS<br><b>MOTHER ABOVE</b>                                                                                                                |                                                                                     |                                                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute propoxyphene intoxication</b><br><b>3047</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                   |                          |                                                                                                                                               |                                                                                                                                           |                                                                                                                                                             |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                         |                          |                                                                                                                                               |                                                                                                                                           |                                                                                                                                                             |                                                                                     |                                                                      |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                             |                                                                                                                                           |                                                                                                                                                             | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                      |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                 |                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                    |                                                                                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                                     |                                                                      |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                              |                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                   |                                                                                                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                     |                                                                      |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                          |                                                                                                                                               |                                                                                                                                           |                                                                                                                                                             |                                                                                     |                                                                      |
| ACTUAL SIGNATURE<br><b>Margie Bre Ynell</b>                                                                                                                                                                                                                                                                                                                                                                                            |                          | M.D. <b>Assistant</b>                                                                                                                         |                                                                                                                                           | MEDICAL EXAMINER                                                                                                                                            |                                                                                     | DATE SIGNED<br><b>6/9/79</b>                                         |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                 |                          | ADDRESS<br><b>111 Penn Street</b>                                                                                                             |                                                                                                                                           |                                                                                                                                                             |                                                                                     |                                                                      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                          |                          | 23b. DATE<br><b>6/11/79</b>                                                                                                                   |                                                                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART</b>                                                                                                   |                                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                           |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>CONNELLY F.H.</b>                                                                                                                                                                                                                                                                                                                                                                                   |                          | ADDRESS<br><b>300 MACE AVE</b>                                                                                                                |                                                                                                                                           | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 15 1979</b>                                                                                                         |                                                                                     | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McBrady</b>                 |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RELEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

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(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                            |  |                                                                                                                            |                                                                        |                                                                                                                                                             |                                                                                                                                                              |                                                                                |                                                                                      |                                                                  |                                                                                                                            | REG. NO. 13758                                       |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Francis George Michaud                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                            |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>June 20, 1979                                                                                                                           |                                                                                |                                                                                      | 2b. HOUR<br>8:25 AM                                              |                                                                                                                            |                                                      |                                              |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>White                                                                                                           |                                                                        | 5. DATE OF BIRTH<br>Jan. 27, 1890                                                                                                                           |                                                                                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS                                      |                                                                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                |                                                                                                                            | 7. IF UNDER 24 HRS<br>HOURS MIN                      |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Massachusetts                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                     |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                  |                                                                                      |                                                                  |                                                                                                                            |                                                      |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holly Hill Manor |                                                                        |                                                                                                                                                             |                                                                                                                                                              | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant    |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Chemical                    |                                                                                                                            |                                                      |                                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                               |  |                                                                                                                            |                                                                        |                                                                                                                                                             | 13b. COUNTY<br>Baltimore                                                                                                                                     |                                                                                | 13c. CITY OR TOWN<br>21204                                                           |                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                                                      | 13e. STREET ADDRESS<br>1218 Brook Meadow Dr. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Michaud                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                            |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Dufresne                                                                                               |                                                                                |                                                                                      |                                                                  |                                                                                                                            |                                                      |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                        |  |                                                                                                                            |                                                                        |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>W.W.I. 096-07-3565                                                                                                               |                                                                                | 17. INFORMANT ADDRESS<br>21204<br>Owen F. Michaud 1218 Brookmeadow Dr.               |                                                                  |                                                                                                                            |                                                      |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u><br>4409<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                            |                                                                        |                                                                                                                                                             |                                                                                                                                                              |                                                                                |                                                                                      |                                                                  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                             |  |                                                                                                                            |                                                                        |                                                                                                                                                             |                                                                                                                                                              |                                                                                |                                                                                      |                                                                  |                                                                                                                            |                                                      |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                                              |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                      |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |  |                                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                                                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                      |                                                                  |                                                                                                                            |                                                      |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                       |  |                                                                                                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                                                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                      |                                                                  |                                                                                                                            |                                                      |                                              |  |
| 22a. I certify that (I) (am hospital) attended the deceased from <u>Aug 10</u> 19 <u>77</u> to <u>June 20</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>June 20</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>examine the body after death</u> .       |  |                                                                                                                            |                                                                        |                                                                                                                                                             |                                                                                                                                                              |                                                                                |                                                                                      |                                                                  |                                                                                                                            |                                                      |                                              |  |
| 22b. SIGNATURE<br><u>Laurence C. Post</u>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                            |                                                                        |                                                                                                                                                             | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                |                                                                                      |                                                                  |                                                                                                                            | 22c. DATE SIGNED<br>6-21-79                          |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Laurence C. Post, M. D.                                                                                                                                                                                                                                                                                                                |  |                                                                                                                            |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br>6805 York Road, Baltimore, Md. 21212                                                                                                         |                                                                                |                                                                                      |                                                                  |                                                                                                                            |                                                      |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                            | 23b. DATE<br>June 22, '79                                              |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Park                                                                                                     |                                                                                |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md. |                                                                                                                            |                                                      |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                            |                                                                        |                                                                                                                                                             | ADDRESS<br>8521 Loch Raven Blvd.                                                                                                                             |                                                                                |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br>JUN 22 1979                     |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><u>Robert H. Brady</u> |                                              |  |

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over 3-400



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                            |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|---------------------------------------------------------------|----------------------|----------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                          |  | 7 9 1 3 7 5 9                                                                                          |                                                                    | REG. NO.                                                                                                                                                 |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                 |  |                                                                                                        | FIRST MIDDLE LAST                                                  |                                                                                                                                                          |                                   | 2a DATE OF DEATH MONTH DAY YEAR                                                                                                            |                                        |                                                               | 2b HOUR a            |                                              |  |
| Dorothy                                                                                                                                                                                                                                                                                                         |  |                                                                                                        | Virginia MILLER                                                    |                                                                                                                                                          |                                   | 6 4 79                                                                                                                                     |                                        |                                                               | 5:40 M               |                                              |  |
| 3 SEX                                                                                                                                                                                                                                                                                                           |  | 4 RACE                                                                                                 |                                                                    | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |                                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                            |                                        | IF UNDER 1 YEAR MONTHS DAYS                                   |                      | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Female                                                                                                                                                                                                                                                                                                          |  | White                                                                                                  |                                                                    | Sept. 5, 1932                                                                                                                                            |                                   | 46 YRS.                                                                                                                                    |                                        |                                                               |                      |                                              |  |
| 7 BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                         |  | 7b CITIZEN OF WHAT COUNTRY?                                                                            |                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                   | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                                                        |                                        |                                                               |                      |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                        |  | U.S.A.                                                                                                 |                                                                    |                                                                                                                                                          |                                   | Baltimore County MD.                                                                                                                       |                                        |                                                               |                      |                                              |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                    |                                                                                                                                                          |                                   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                               |                                        | 12b KIND OF BUSINESS OR INDUSTRY                              |                      |                                              |  |
| Rosedale                                                                                                                                                                                                                                                                                                        |  | Franklin Square Hospital                                                                               |                                                                    |                                                                                                                                                          |                                   | Meat cutter                                                                                                                                |                                        | Food                                                          |                      |                                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                         |  |                                                                                                        | 13a. COUNTY                                                        |                                                                                                                                                          |                                   | 13b. CITY OR TOWN                                                                                                                          |                                        |                                                               | 13c. STREET ADDRESS  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                        |  |                                                                                                        | Harford                                                            |                                                                                                                                                          |                                   | Bel Air                                                                                                                                    |                                        |                                                               | 485 Moores Mill Road |                                              |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                              |  |                                                                                                        | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
| Earl Heaps Schilling                                                                                                                                                                                                                                                                                            |  |                                                                                                        | Florence Young                                                     |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                |  |                                                                                                        | 16b SOCIAL SECURITY NO.                                            |                                                                                                                                                          |                                   | 17 INFORMANT ADDRESS                                                                                                                       |                                        |                                                               |                      |                                              |  |
| No                                                                                                                                                                                                                                                                                                              |  |                                                                                                        | 213-28-3700                                                        |                                                                                                                                                          |                                   | William E. Miller Bel Air, Md.                                                                                                             |                                        |                                                               |                      |                                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.                                                                                                                                                                                                            |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Cardio-pulmonary arrest                                                                                                                                                                                                                                                                     |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
| 5715 } DUE TO, OR AS A CONSEQUENCE OF Liver cirrhosis with severe ascites                                                                                                                                                                                                                                       |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                  |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF Possible peritonitis                                                                                                                                                                                                                                                             |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                              |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                           |  |                                                                                                        | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                          |                                   | 20a AUTOPSY?                                                                                                                               |                                        | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                      |                                              |  |
|                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                        | YES <input type="checkbox"/> NO <input type="checkbox"/>      |                      |                                              |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                               |  |                                                                                                        | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |                                                                                                                                                          |                                   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                              |                                        |                                                               |                      |                                              |  |
|                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        | P.M. 19                                                            |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                           |  |                                                                                                        | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                          |                                   | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                              |                                        |                                                               |                      |                                              |  |
|                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from 5/24/ 19 79, to 6/4/ 19 79, that (I) (we) last saw the deceased alive on 6/4/ 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
| 22b SIGNATURE                                                                                                                                                                                                                                                                                                   |  |                                                                                                        | DEGREE                                                             |                                                                                                                                                          |                                   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                        |                                                               | 22c DATE SIGNED      |                                              |  |
| L. Chow, M.D.                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |                                                                    |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               | 6/4/79               |                                              |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                            |  |                                                                                                        | 22e ADDRESS                                                        |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
| L. Chow, M.D.                                                                                                                                                                                                                                                                                                   |  |                                                                                                        | 9000 Franklin Square Drive                                         |                                                                                                                                                          |                                   |                                                                                                                                            |                                        |                                                               |                      |                                              |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                        |  |                                                                                                        | 23b DATE                                                           |                                                                                                                                                          | 23c NAME OF CEMETERY OR CREMATORY |                                                                                                                                            | 23d LOCATION CITY OR TOWN COUNTY STATE |                                                               |                      |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                          |  |                                                                                                        | 6/6/1979                                                           |                                                                                                                                                          | Jarrettsville Cem.                |                                                                                                                                            | Jarrettsville, Harford, Md.            |                                                               |                      |                                              |  |
| 24 FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                        |  |                                                                                                        | ADDRESS                                                            |                                                                                                                                                          |                                   | 25a DATE REC'D. BY REGISTRAR                                                                                                               |                                        | 25b REGISTRAR'S SIGNATURE                                     |                      |                                              |  |
| M. G. Kurtz III                                                                                                                                                                                                                                                                                                 |  |                                                                                                        | Jarrettsville, Md.                                                 |                                                                                                                                                          |                                   | JUN 6 1979                                                                                                                                 |                                        | L. Chow, M.D.                                                 |                      |                                              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                                                            |  | 79 13760<br>REG. NO.                                                                            |  |                      |  |                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------|--|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Estelle H. Miller</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 3 79</b>                                  |  | 2b. HOUR<br>M<br><b>M</b>                                                                                                  |  |                                                                                                 |  |                      |  |                                      |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>White</b>                                                                                                                 |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 7 04</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                                                            |  | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b>                                                  |  |                      |  |                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                   |  |                                                                                                                            |  |                                                                                                 |  |                      |  |                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7581 Westfield Road</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dev. Co.</b>                                                                       |  |                                                                                                 |  |                      |  |                                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |  |                                                                                                                                                             |  | 13b. COUNTY<br><b>Baltimore</b>                                                       |  | 13c. CITY OR TOWN<br><b>Dundalk</b>                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                      |  |                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Henry</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lula Smith</b>                    |  |                                                                                                                            |  |                                                                                                 |  |                      |  |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><b>218-01-0952</b>                                                                                          |  | 17. INFORMANT<br><b>Peter G. Yeagy</b>                                                                                                                      |  |                                                                                       |  | ADDRESS<br><b>2218 Searles Rd. Balto. MD 21222</b>                                                                         |  |                                                                                                 |  |                      |  |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b><br><b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Diabetes</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                    |  |                      |  |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Hypertension</b>                                                                                                                                                                                                                                                |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                                                            |  |                                                                                                 |  |                      |  |                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                 |  |                      |  |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                       |  |                                                                                                                            |  |                                                                                                 |  |                      |  |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION<br>STREET<br><b>7811 Wise Ave</b>                                                                                                             |  | CITY OR TOWN<br><b>Baltimore</b>                                                      |  | COUNTY<br><b>Maryland</b>                                                                                                  |  | STATE                                                                                           |  |                      |  |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1979</b> , 19 <b>79</b> , to <b>May 30</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>May 30</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                          |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                                                            |  | 22b. SIGNATURE<br><b>R. S. MAGNO, MD.</b>                                                       |  | DEGREE<br><b>MD.</b> |  | 22c. DATE SIGNED<br><b>JUNE 1979</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. S. MAGNO, MD.</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         |  | 22e. ADDRESS<br><b>7811 Wise Ave</b>                                                                                                                        |  |                                                                                       |  |                                                                                                                            |  |                                                                                                 |  |                      |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>6/6/79</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>                                     |  | COUNTY<br><b>Maryland</b>                                                                                                  |  | STATE                                                                                           |  |                      |  |                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |  | ADDRESS<br><b>7922 Wise Avenue, Dundalk, MD 21222</b>                                                                                                       |  |                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUNE 1979</b>                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>Richard McBrady</b>                                            |  |                      |  |                                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                         |  | 79 13761<br>REG. NO.                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>IRA E. MILLER                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                 |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6-19-79                                                  |  | 2b. HOUR<br>540 AM                                                                                                            |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>WHITE                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6-2-10                                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.                                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                     |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>PA                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                             |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CO MD.                                        |  |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SAINT JOSEPH HOSP. |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>WIREMAN                     |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>ELECTRIC CO                                                                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br>BALTO                                                                                                            |  | 13c. CITY OR TOWN<br>HYDES                                                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>Hydes, Md. 21082<br>REGWOOD RD                                                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Cortney Miller                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mabel unk. Miller                                                                                          |  |                                                                                                 |  |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>UNK No                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>213-01-3754                                                                                                                     |  | 17. INFORMANT<br>ADDRESS Hydes, Md. 21082<br>Mrs. Kathryn R. Miller, 12605 Regwood Rd.          |  |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST<br>492-<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last<br>(b) GRAM NEGATIVE PNEUMONIA<br>(c) SEVERE EMPHYSEMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                 |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                               |  |
| 22a. I certify that (this hospital) attended the deceased from 5-31, 1979, to 6-19, 1979, that (I) saw the deceased alive on 6-19, 1979, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                          |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |  |
| 22b. SIGNATURE<br>W. Robert Lange MD                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                 |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                                 |  | 22c. DATE SIGNED<br>6-19-79                                                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W. ROBERT LANGE, MD                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                 |  | 22e. ADDRESS<br>SAINT JOSEPH HOSP.                                                                                                                          |  |                                                                                                 |  |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br>6-22-1979                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley M. G.                                                                                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Timonium Balto. Md.                               |  |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>E. F. Lassahn, 11750 Belair Rd., Baltimore, Md. 21087                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 21 1979                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>Kathryn R. Miller                                                 |  |                                                                                                                               |  |

1 2 1 0 1

UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C.



MEMORANDUM FOR THE CHIEF OF STAFF  
SUBJECT: [Illegible]  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 3 7 6 2

REG. NO.

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                     |                                                                         |                                                                                                                                                             |                                                                                |                                                                               |                                                                                                 |                                               |                                                                                                                            |                                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Coca M. Mitchell                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5/28/79                          |                                                                                                                                                             |                                                                                | 2b. HOUR<br>3:20A M                                                           |                                                                                                 |                                               |                                                                                                                            |                                           |  |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>W                                                                                                                        |                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10th 1896<br>4 24 79                                                                                                  |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.                                    |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.     |                                                                                                                            |                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                 |                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |                                                                                                 |                                               |                                                                                                                            |                                           |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Chapel Hill Conv. Home |                                                                         |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dietician |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hospital |                                                                                                                            |                                           |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     | 13b. COUNTY<br>--                                                       |                                                                                                                                                             | 13c. CITY OR TOWN<br>Balto.                                                    |                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                               | 13e. STREET ADDRESS<br>3637 Sussex Road                                                                                    |                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank -- Wissig                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     |                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cora Tighlman                                                                                              |                                                                                |                                                                               |                                                                                                 |                                               |                                                                                                                            |                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                               |  |                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-12-6138A |                                                                                                                                                             | 17. INFORMANT ADDRESS                                                          |                                                                               |                                                                                                 |                                               |                                                                                                                            |                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Carcinoma<br>1629 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Lung. }<br>(b) }<br>(c) } DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                     |                                                                         |                                                                                                                                                             |                                                                                |                                                                               |                                                                                                 |                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 mos<br>2 yrs                                                             |                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a)                                                                                                                                                                                                                      |  |                                                                                                                                     |                                                                         |                                                                                                                                                             |                                                                                |                                                                               |                                                                                                 |                                               |                                                                                                                            |                                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |                                                                                                                                                             |                                                                                |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                 |  |                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                               |                                                                                                 |                                               |                                                                                                                            |                                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                             |  |                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                               |                                                                                                 |                                               |                                                                                                                            |                                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 70, to 5/28, 19 79, that (I) (we) lost<br>saw the deceased alive on 5/28, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) did (did not) view the body after death.                                          |  |                                                                                                                                     |                                                                         |                                                                                                                                                             |                                                                                |                                                                               |                                                                                                 |                                               |                                                                                                                            |                                           |  |
| 22b. SIGNATURE<br>W. J. S. Hillin, MD                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |                                                                         |                                                                                                                                                             |                                                                                | DEGREE<br>MD                                                                  |                                                                                                 | 22c. DATE SIGNED<br>6/1/79                    |                                                                                                                            |                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. J. Hillin                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |                                                                         |                                                                                                                                                             |                                                                                | 22e. ADDRESS<br>Randallstown, Md.                                             |                                                                                                 |                                               |                                                                                                                            |                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     | 23b. DATE<br>5/28/79                                                    |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                                                               |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE    |                                                                                                                            |                                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                     |                                                                         |                                                                                                                                                             |                                                                                | ADDRESS<br>Balto., Md.                                                        |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>JUN 8 1979   |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br>L. H. H. H. |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 1/75  
(VR A 15 (4))

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                |  |                                                                               |  |                                                                                                                                                          |  |                                                                |  |                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                            |  | 2a. DATE OF DEATH                                                             |  | 2b. DATE OF DEATH                                                                                                                                        |  | 2c. HOUR                                                       |  | 2d. MIN.               |  |
| PARKE                                                                                                                                                                                                                                                                                                          |  | WELLINGTON MOLESWORTH                                                         |  | 06 09 79                                                                                                                                                 |  | 7:42P                                                          |  | M                      |  |
| 3. SEX                                                                                                                                                                                                                                                                                                         |  | 4. RACE                                                                       |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | 7. IF UNDER 1 YEAR     |  |
| MALE                                                                                                                                                                                                                                                                                                           |  | WHITE                                                                         |  | 10 27 97                                                                                                                                                 |  | 81                                                             |  | MONTHS DAYS HOURS MIN. |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                      |  | 7c. CITIZEN OF WHAT COUNTRY?                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  | 10. BALTO. COUNTY, MD. |  |
| MARYLAND                                                                                                                                                                                                                                                                                                       |  | USA                                                                           |  |                                                                                                                                                          |  | BALTO. COUNTY,                                                 |  |                        |  |
| 11. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                      |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) |  | 13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 13b. KIND OF BUSINESS OR INDUSTRY                              |  | 14. BALTO. TRANSI      |  |
| TOWSON, MD.                                                                                                                                                                                                                                                                                                    |  | G.B.M.C.                                                                      |  |                                                                                                                                                          |  |                                                                |  |                        |  |
| 15a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                   |  | 15b. STATE                                                                    |  | 15c. COUNTY                                                                                                                                              |  | 15d. CITY OR TOWN                                              |  | 15e. STREET ADDRESS    |  |
| MARYLAND                                                                                                                                                                                                                                                                                                       |  |                                                                               |  |                                                                                                                                                          |  | BALTIMORE                                                      |  | 1 KNOLL RIDGE COURT    |  |
| 16. FATHER'S NAME                                                                                                                                                                                                                                                                                              |  | 16. MOTHER'S MAIDEN NAME                                                      |  | 16. FIRST                                                                                                                                                |  | 16. MIDDLE                                                     |  | 16. LAST               |  |
| ROY WELLINGTON MOLESWORTH                                                                                                                                                                                                                                                                                      |  | MAMIE DIEHL JUSTUS                                                            |  |                                                                                                                                                          |  |                                                                |  |                        |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                              |  | 17b. SOCIAL SECURITY NO.                                                      |  | 17. INFORMANT                                                                                                                                            |  | 17. ADDRESS                                                    |  | 17. SAME               |  |
| NO                                                                                                                                                                                                                                                                                                             |  | 215-09-3565                                                                   |  | MRS. LILLIAN KNILL MOLESWORTH                                                                                                                            |  |                                                                |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                          |  | 18. IMMEDIATE CAUSE (a)                                                       |  | 18. DUE TO, OR AS A CONSEQUENCE OF                                                                                                                       |  | 18. (b)                                                        |  | 18. (c)                |  |
| 4149                                                                                                                                                                                                                                                                                                           |  | CARDIO-PULMONARY ARREST                                                       |  | CORONARY ISHEMIA                                                                                                                                         |  | 3 DAYS                                                         |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                            |  |                                                                               |  |                                                                                                                                                          |  |                                                                |  |                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                        |  |
|                                                                                                                                                                                                                                                                                                                |  |                                                                               |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                |  |                        |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 9, 1979, to June 9, 1979, that (I) (we) saw the deceased alive on June 9, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  | 22b. SIGNATURE S. J. VENABLE JR M.D.                                          |  | 22c. DEGREE M.D.                                                                                                                                         |  | 22d. DATE SIGNED 6-10-79                                       |  |                        |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                          |  | 22f. ADDRESS                                                                  |  |                                                                                                                                                          |  |                                                                |  |                        |  |
| S. J. VENABLE JR M.D.                                                                                                                                                                                                                                                                                          |  | 7215 YORK RD-BALTIMORE MD 21212                                               |  |                                                                                                                                                          |  |                                                                |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                      |  | 23b. DATE                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |                        |  |
| BURIAL                                                                                                                                                                                                                                                                                                         |  | JUNE 12, 1979                                                                 |  | MT. OLIVET                                                                                                                                               |  | FREDERICK, WASHINGTON, MD.                                     |  |                        |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                      |  | 24. ADDRESS                                                                   |  | 24. DATE RECEIVED BY REGISTRAR                                                                                                                           |  | 24. REGISTRAR'S SIGNATURE                                      |  |                        |  |
| MITCHELL-WIEDEFELD HOME, INC. BALTO., MD.                                                                                                                                                                                                                                                                      |  | 6500 YORK RD.                                                                 |  | JUNE 11 1979                                                                                                                                             |  |                                                                |  |                        |  |

00101 11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                     |                                                                                                 |                                                                                                                                                            |                                                                                |                                                                                        |                                                               |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>MARY C MOLZ</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 14 1979</b>                                         |                                                                                                                                                            |                                                                                | 2b. HOUR <b>5:30</b> P M                                                               |                                                               |                                                                                                                            |  |
| 3 SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                                           |  | 4 RACE <b>White</b>                                                                                                                 |                                                                                                 | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>NOV 20 1883</b>                                                                                                       |                                                                                | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b> YRS                                        |                                                               | 7 IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                          |                                                                                                 | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO Co. MD.</b>                            |                                                               |                                                                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br><b>PARKVILLE</b>                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2956 MANN'S AVE</b> |                                                                                                 |                                                                                                                                                            |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housekeeper</b> |                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>                                                                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO</b> 13c. CITY OR TOWN <b>Parkville</b>                                                                                                                                                                                                   |  |                                                                                                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                                            | 13e. STREET ADDRESS<br><b>2956 MANN'S AVE</b>                                  |                                                                                        |                                                               |                                                                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>LOUIS C MOELLEN</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ELIZABETH TRAEGER</b>                          |                                                                                                                                                            |                                                                                |                                                                                        |                                                               |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br><b>218-10-9698</b>                                                  |                                                                                                                                                            | 17. INFORMANT ADDRESS<br><b>Family Records</b>                                 |                                                                                        |                                                               |                                                                                                                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio-vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                     |                                                                                                 |                                                                                                                                                            |                                                                                |                                                                                        |                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 years</b>                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                            |  |                                                                                                                                     |                                                                                                 |                                                                                                                                                            |                                                                                |                                                                                        |                                                               |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                |                                                                                                                                                            |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                      |  |                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                      |                                                                                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                        |                                                               |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                     |  |                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)                           |                                                                                                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                        |                                                               |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 19 1976</b> to <b>June 14 19 79</b> , that (I) (we) last saw the deceased alive on <b>June 14 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |                                                                                                                                     |                                                                                                 |                                                                                                                                                            |                                                                                |                                                                                        |                                                               |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>B. B. Velez, M.D.</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     | 22c. DATE SIGNED<br><b>6-16-79</b>                                                              |                                                                                                                                                            |                                                                                | 22d. ADDRESS<br><b>9515 HARFORD RD BALTO, MD 21234</b>                                 |                                                               |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BORIAL</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     | 23b. DATE<br><b>6/18/79</b>                                                                     |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>                     |                                                                                        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS Funeral Chapel</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                     | ADDRESS<br><b>8800 HARFORD RD</b>                                                               |                                                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>                            |                                                                                        | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>           |                                                                                                                            |  |

MEDICAL CERTIFICATION

1 2 3 4 5 6 7 8 9 10 11 12



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 13765

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                       |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|---------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------|----------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                   |  |         | 2a. DATE OF DEATH                                       |                                                                                    |                                    | 2b. HOUR                                                                                                                                   |               |                                                                |                                                          |  |
| FIRST MARY                                                                                                                                            |  |         | MONTH 6                                                 |                                                                                    |                                    | DAY 18                                                                                                                                     |               |                                                                |                                                          |  |
| MIDDLE W.                                                                                                                                             |  |         | YEAR 79                                                 |                                                                                    |                                    | A M                                                                                                                                        |               |                                                                |                                                          |  |
| LAST MORRIS                                                                                                                                           |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| 3. SEX                                                                                                                                                |  | 4. RACE |                                                         | 5. DATE OF BIRTH                                                                   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                            |               | 7. IF UNDER 1 YEAR                                             |                                                          |  |
| Female                                                                                                                                                |  | Cau.    |                                                         | MONTH 12                                                                           |                                    | DAY 17                                                                                                                                     |               | YEAR 93                                                        |                                                          |  |
|                                                                                                                                                       |  |         |                                                         | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |                                    | YRS 84                                                                                                                                     |               | MONTHS                                                         |                                                          |  |
|                                                                                                                                                       |  |         |                                                         | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                 |                                    |                                                                                                                                            |               | DAYS                                                           |                                                          |  |
|                                                                                                                                                       |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               | HOURS                                                          |                                                          |  |
|                                                                                                                                                       |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               | MIN.                                                           |                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                             |  |         | 7b. CITIZEN OF WHAT COUNTRY?                            |                                                                                    |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |               |                                                                |                                                          |  |
| Baltimore, Md.                                                                                                                                        |  |         | U.S.                                                    |                                                                                    |                                    | Baltimore County                                                                                                                           |               |                                                                | MD.                                                      |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                             |  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |                                                                                    |                                    | 12a. USUAL OCCUPATION                                                                                                                      |               |                                                                | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |
| Catonsville                                                                                                                                           |  |         | House in the Pines                                      |                                                                                    |                                    | HOUSE WIFE                                                                                                                                 |               |                                                                |                                                          |  |
| 13a. STATE                                                                                                                                            |  |         | 13b. COUNTY                                             |                                                                                    |                                    | 13c. CITY OR TOWN                                                                                                                          |               |                                                                | 13d. INSIDE CITY LIMITS?                                 |  |
| Maryland                                                                                                                                              |  |         | HOW                                                     |                                                                                    |                                    | Baltimore                                                                                                                                  |               |                                                                | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME                                                                                                                                     |  |         | 15. MOTHER'S MAIDEN NAME                                |                                                                                    |                                    | 13e. STREET ADDRESS                                                                                                                        |               |                                                                |                                                          |  |
| FIRST MIDDLE LAST                                                                                                                                     |  |         | FIRST MIDDLE LAST                                       |                                                                                    |                                    | 6393 W. Rockburn Hill                                                                                                                      |               |                                                                |                                                          |  |
| George                                                                                                                                                |  |         | WORTHINGTON                                             |                                                                                    |                                    | Mary                                                                                                                                       |               |                                                                | Parker                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                          |  |         | 16b. SOCIAL SECURITY NO.                                |                                                                                    |                                    | 17. INFORMANT                                                                                                                              |               |                                                                | ADDRESS                                                  |  |
| (YES, NO OR UNKNOWN)                                                                                                                                  |  |         | (IF YES, GIVE WAR OR DATES)                             |                                                                                    |                                    | House in the Pines                                                                                                                         |               |                                                                | 16 Fusting Avenue                                        |  |
| NO                                                                                                                                                    |  |         | 217-38-0324                                             |                                                                                    |                                    | Baltimore, Md.                                                                                                                             |               |                                                                | 21228                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                             |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |                                                          |  |
| PART I. DEATH WAS CAUSED BY                                                                                                                           |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i>                                                                                             |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               | 12 hr.                                                         |                                                          |  |
| 4292 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                   |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| (b) <i>A.D. C.V.D.</i>                                                                                                                                |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               | 10 years                                                       |                                                          |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                        |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| (c)                                                                                                                                                   |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                   |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| <i>Chronic Brain Syndrome</i>                                                                                                                         |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |                                                                                    |                                    | 20a. AUTOPSY?                                                                                                                              |               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                                          |  |
|                                                                                                                                                       |  |         |                                                         |                                                                                    |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |               | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>                                                                                                 |  |         | 21b. TIME OF INJURY                                     |                                                                                    |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |               |                                                                |                                                          |  |
| OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                               |  |         | HOUR A.M. MONTH DAY YEAR                                |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                  |  |         | P.M. 19                                                 |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| 21d. INJURY OCCURRED                                                                                                                                  |  |         | 21e. PLACE OF INJURY                                    |                                                                                    |                                    | 21f. LOCATION                                                                                                                              |               |                                                                |                                                          |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>                                                                                     |  |         | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |                                                                                    |                                    | STREET CITY OR TOWN COUNTY STATE                                                                                                           |               |                                                                |                                                          |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                     |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 9</i> 19 <i>79</i> to <i>June 18</i> 19 <i>79</i> , that (I) (we) lost     |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| saw the deceased alive on <i>June 16</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| above, (I) (we) (did not) view the body after death.                                                                                                  |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| 22b. SIGNATURE                                                                                                                                        |  |         |                                                         |                                                                                    |                                    | DEGREE                                                                                                                                     |               | 22c. DATE SIGNED                                               |                                                          |  |
| <i>Wilmer K. Gallagher, Sr.</i>                                                                                                                       |  |         |                                                         |                                                                                    |                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |               | 6-18-79                                                        |                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                 |  |         |                                                         |                                                                                    |                                    | 22e. ADDRESS                                                                                                                               |               |                                                                |                                                          |  |
| Dr. Wilmer Gallagher, Sr.                                                                                                                             |  |         |                                                         |                                                                                    |                                    | 6209 Frederick Road, Baltimore, Md. 21228                                                                                                  |               |                                                                |                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                             |  |         | 23b. DATE                                               |                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY |                                                                                                                                            | 23d. LOCATION |                                                                | 23e. STATE                                               |  |
| BURIAL                                                                                                                                                |  |         | 6/21/79                                                 |                                                                                    | GRACE CHURCH CEM.                  |                                                                                                                                            | ELKRIODE MO   |                                                                | 31227                                                    |  |
| 24. FUNERAL DIRECTOR                                                                                                                                  |  |         |                                                         |                                                                                    |                                    | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |               | 25b. REGISTRAR'S SIGNATURE                                     |                                                          |  |
| NAME                                                                                                                                                  |  |         |                                                         |                                                                                    |                                    | JUN 19 1979                                                                                                                                |               | <i>Robert H. H. H.</i>                                         |                                                          |  |
| JOSEPH L. CANBY 12570 INDIAN HILL DR                                                                                                                  |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |
| WEST FRIENDSHIP MD 21794                                                                                                                              |  |         |                                                         |                                                                                    |                                    |                                                                                                                                            |               |                                                                |                                                          |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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11



12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                          |                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                             |  | 79 13766<br>REG. NO.                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                          |                                                 |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ilene Ruth Neighoff                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 5 1979                                   |  | 2b. HOUR<br>2:45 AM                                                                                                                      |                                                 |
| 3. SEX<br>F =                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>W                                                                                                                            |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 12 1927                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                                         |                                                 |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |                                                                                                                                          |                                                 |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Balto. Med. Center |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Quality Cont.    |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Noxell                                                                                           |                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland                                                                                                                                                                                                                                                      |  |                                                                                                                                         |  |                                                                                                                                                             |  | 13b. COUNTY Baltimore                                                                |  | 13c. CITY OR TOWN Baltimore                                                                                                              |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry T. Crawford                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret L. Beeker                  |  |                                                                                                                                          |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>214-22-8684                                                                                                 |  | 17. INFORMANT<br>ADDRESS<br>John E. Neighoff, 3103 Chestnut Ave.                                                                                            |  |                                                                                      |  |                                                                                                                                          |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of right lung<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Endocarditis with renal infarcts                                                                                                                                                                                                  |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                          |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                      |  |                                                                                                                                          |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                      |  |                                                                                                                                          |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/21, 1979, to 6/5/1979, that (I) (we) lost<br>saw the deceased alive on 6/5/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                        |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                                          |                                                 |
| 22b. SIGNATURE<br>R. Breitenacker                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>6/5/79                                                           |  |                                                                                                                                          |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Rudiger Breitenacker, M.D.                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         |  | 22e. ADDRESS<br>6701 N. Charles St. Towson, Md. 21204                                                                                                       |  |                                                                                      |  |                                                                                                                                          |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>June 8, 1979                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Middletown Meth.                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                             |  |                                                                                                                                          |                                                 |
| 24. FUNERAL DIRECTOR<br>A. ALAN SEITZ FUNERAL HOME,<br>3818 Roland Ave., Balto., Md. 21211                                                                                                                                                                                                                                                                               |  |                                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 13 1979                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>Rufus M. Brady                                         |  |                                                                                                                                          |                                                 |

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 1 3 7 6 7  
REG. NO.

|                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |                                                       |                                                                                                                                                             |                                                                              |                                                                                     |  |                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY Mildred Neser</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6/18/79</b> |                                                                                                                                                             |                                                                              | 2b. HOUR<br><b>1 AM</b> M                                                           |  |                                                                |  |
| 3. SEX<br><b>F.</b>                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>Can.</b>                                                                                                                   |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 13 1896</b>                                                                                                      |                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> 82 YRS                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                                                                              |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto County</b> MD.                     |  |                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |                                                       |                                                                                                                                                             |                                                                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Book keeper</b>        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Towson</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>Dulaney Valley Road.</b> |  |                                                                                                                                          |                                                       |                                                                                                                                                             |                                                                              |                                                                                     |  |                                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John H Neser</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                          |                                                       |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Elizabeth Smith</b> |                                                                                     |  |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br><b>21203 1906</b>                                                                                            |                                                       | 17. INFORMANT<br>NAME ADDRESS<br><b>Joseph Schmidt 404 Glenmont Ave</b>                                                                                     |                                                                              |                                                                                     |  |                                                                |  |

|                                                                                                                                                                                                                                                                                                                                                                             |  |                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CVA</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Secondary to A.S.C.V.D.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Mon.</b> |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------|--|

|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/14</b> , 19 <b>76</b> , to <b>6/18</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>ELR</b>                                                                                                                                                                                                                                                                                                                                       |  | DEGREE                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/18/79</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR LEE Robbins M.D.</b>                                                                                                                                                                                                                                                                                                |  |                                                                        |  | 22e. ADDRESS<br><b>1205 York Rd. Lutherville Md.</b>                                                                                       |  |                                                                                                                            |  |

|                                                                                                                |  |                                   |  |                                                                     |  |                                                                          |  |
|----------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|---------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                  |  | 23b. DATE<br><b>June 21, 1979</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry Helms</b>                         |  |

1 2 1 0 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If a body is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                                                             |  |                                                                           |  |                                                                                                                               |  | 79 13768 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                    |  | REG. NO.                                                                                                                                   |  |                                                                                                                                                             |  |                                                                           |  |                                                                                                                               |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MARY BEATRICE NORRIS                                                                                                                                                                                                                                   |  |                                                                                                                                            |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>6 21 79                               |  | 2b. HOUR<br>3 30 A.M.                                                                                                         |  |          |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                |  | 4. RACE<br>Cau.                                                                                                                            |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 24 1909                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                     |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>St. Marys County                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.             |  |                                                                                                                               |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>STELLA MARIS HOSPICE BOX ASS. |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RET.  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |  |          |  |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                               |  |                                                                                                                                            |  |                                                                                                                                                             |  | 13b. COUNTY<br>BALT.                                                      |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE S. NORRIS                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FLORENCE M. FERRALL                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br>218 S. AUGUSTA AVE.                                |  |                                                                                                                               |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-22-4287A                                                                    |  | 17. INFORMANT<br>ADDRESS<br>STELLA MARIS TOWSON, MD.                                                                                                        |  |                                                                           |  |                                                                                                                               |  |          |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASCVD<br>1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CA. OF STOMACH<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                   |  |                                                                                                                                            |  |                                                                                                                                                             |  |                                                                           |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                              |  |                                                                                                                                            |  |                                                                                                                                                             |  |                                                                           |  |                                                                                                                               |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                           |  |                                                                                                                               |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                           |  |                                                                                                                               |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-15, 1974, to 6-21, 1979, that (I) (we) last saw the deceased alive on 6-21, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                            |  |                                                                                                                                                             |  |                                                                           |  |                                                                                                                               |  |          |  |
| 22b. SIGNATURE<br>[Signature]                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>6/21/79                                               |  |                                                                                                                               |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. E. L. ROBBINS                                                                                                                                                                                                                                                      |  |                                                                                                                                            |  | 22e. ADDRESS<br>1205 YORK RD. LUTHERVILLE, MD.                                                                                                              |  |                                                                           |  |                                                                                                                               |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                          |  | 23b. DATE<br>June 23, 1979                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Our Lady's Chapel Cem.                                                                                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Medleys Neck, St. Mary, Md. |  |                                                                                                                               |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204                                                                                                                                                                                                                                |  |                                                                                                                                            |  | 450 York Road<br>ADDRESS                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 22 1979                              |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                     |  |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                    |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                             |                                                                                                                               |                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |  |                                                                                                                                                             | 7 9 1 3 7 6 9<br>REG. NO.                                                                                                                            |                                                                                      |                             |                                                                                                                               |                                                                                                 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Louis J. Novak                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 10, 1979                                                                                                 |                                                                                      |                             | 2b. HOUR<br>4:35A M                                                                                                           |                                                                                                 |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>White                                                                                                                      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 2, 1905                                                                                                          |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                           |                             | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                                                                 |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD.                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                        |                             |                                                                                                                               |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Oil Refinery     |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                                                                                        |                                                                                                 |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  |                                                                                                                                                             | 13b. COUNTY                                                                                                                                          |                                                                                      | 13c. CITY OR TOWN<br>Balto. |                                                                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Novak                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annette Rokosky                                                                                     |                                                                                      |                             |                                                                                                                               |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II                                                                      |  | 17. INFORMANT<br>ADDRESS<br>Marie Kempter (sister) Chambersburg, Penna.                                                                                     |                                                                                                                                                      |                                                                                      |                             |                                                                                                                               |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory Arrest<br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Metastatic Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Cancer of Colon                                   |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                             |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>Bilateral Hydronephrosis with Uremia                                                                                                                                            |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                             |                                                                                                                               |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  |                                                                                                                                                             |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                             | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                                                                      |                                                                                      |                             |                                                                                                                               |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                                                      |                                                                                      |                             |                                                                                                                               |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 24, 1979, to June 10, 1979, that (I) (we) lost saw the deceased alive on June 10, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If used, (I) did not view the body after death.) |  |                                                                                                                                       |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                             |                                                                                                                               |                                                                                                 |  |
| 22b. SIGNATURE<br>Jean-Pierre                                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |  |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                      | 22c. DATE SIGNED<br>6/10/79 |                                                                                                                               |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jacques Jean-Pierre, M.D.                                                                                                                                                                                                                                                      |  |                                                                                                                                       |  |                                                                                                                                                             | 22e. ADDRESS<br>9000 Franklin Square Drive 21237                                                                                                     |                                                                                      |                             |                                                                                                                               |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>6/13/79                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cemetery                                                                                                   |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                             |                             |                                                                                                                               |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 11 1979                                                                                                                |                                                                                                                                                      | 25b. REGISTRAR'S SIGNATURE<br>Rafael A. Cruz                                         |                             |                                                                                                                               |                                                                                                 |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                  |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>1 - STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                        |  | 7 9                                                                                                                                                                                              |                                                | 1 3 7 7 0                                                                                                                                                   |  | REG. NO.                                                                                        |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Anna C. O'Brien                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6/15/79 |                                                                                                                                                             |  | 2b. HOUR<br>5 AM                                                                                |  |                                                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>White                                                                                                                                                                                 |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 29 1922                                                                                                             |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br>77 YRS.                                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penn                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                           |                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Maryland Hospital for the Elderly<br>509 E. Joppa Rd 21204 |                                                |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Book Binder                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Book                                                                                  |  |
| 13a. STATE<br>Md                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br>Baltimore                                                                                                                                                                         |                                                | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>100 N Broadway                                                                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Murphy                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes McNeal                                                                                                                                    |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br>215-09-4863                                                                                                                                                          |                                                | 17. INFORMANT<br>ADDRESS<br>Patricia Brennan 8418 King Rd                                                                                                   |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Heart Failure<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) A.S.C. V.D.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) |  |                                                                                                                                                                                                  |                                                |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                     |  |                                                                                                                                                                                                  |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                 |                                                |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                       |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                           |                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                          |  |                                                                                                                                                                                                  |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Lester Keys                                                                                                                                                                                                                                                                                                                           |  | DEGREE                                                                                                                                                                                           |                                                | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  |                                                                                                 |  | 22c. DATE SIGNED<br>6/15/79                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Walter Keys                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                  |                                                | 22e. ADDRESS<br>509 E Joppa Rd                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>6/16/79                                                                                                                                                                             |                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral                                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md                                      |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Evans Funeral Chapel                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                  |                                                | ADDRESS<br>8800 Hartford Rd                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 19 1979                                                    |  | 25b. REGISTRAR'S SIGNATURE<br>Lester Keys                                                                                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Populations retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                         |  |                                                                                                                                                       |  | REG. NO. 9 13771                                                                                                                                            |  |                                                                                                                         |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CARROLL</b> <b>O'CONNOR</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                       |  | 2a. DATE OF DEATH MONTH <b>6</b> DAY <b>8</b> YEAR <b>79</b>                                                                                                |  |                                                                                                                         |                                              |
| 3. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE <b>W</b>                                                                                                                                      |  | 5. DATE OF BIRTH MONTH <b>12</b> DAY <b>22</b> YEAR <b>23</b>                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> 56 YRS.                                                                       |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY MD.</b>                                                           |                                              |
| 10. CITY OR TOWN OF DEATH <b>ESSEX</b>                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTO. CITY HOSP.</b>                       |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POLICE</b>                                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                |  |                                                                                                                         |                                              |
| 13a. STATE <b>MD.</b>                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY <b>BALTO</b>                                                                                                                              |  | 13c. CITY OR TOWN <b>ESSEX</b>                                                                                                                              |  | 13e. STREET ADDRESS <b>62 BELKSHIRE RD.</b>                                                                             |                                              |
| 14. FATHER'S NAME FIRST <b>FRANK</b> MIDDLE <b>V.</b> LAST <b>O'CONNOR</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME FIRST <b>EMMA</b> MIDDLE <b>HAMILTON</b> LAST <b>HAMILTON</b>                                                                      |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO. <b>WW 216-14-1069</b>                                                                                                        |  | 17. INFORMANT ADDRESS <b>ELIZABETH O'CONNOR ABOVE</b>                                                                                                       |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4254</b> IMMEDIATE CAUSE (a) <b>cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                           |  |                                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                      |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/8</b> 19 <b>79</b> , to <b>6/8</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/8</b> 19 <b>79</b> , and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.        |  |                                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 22b. SIGNATURE <b>P. B. Lyon</b>                                                                                                                                                                                                                                                                                                                             |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>6/8/79</b>                                                                                                                              |  |                                                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. B. Lyon</b>                                                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS <b>Baltimore City Hospital.</b>                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                      |  | 23b. DATE <b>6-13-79</b>                                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HOLLY HILL</b>                                                                                                        |  | 23d. LOCATION CITY OR TOWN <b>ESSEX</b> COUNTY <b>BALTO</b> STATE <b>MD.</b>                                            |                                              |
| 24. FUNERAL DIRECTOR NAME <b>COWNELLY F.H.</b> ADDRESS <b>300 MACE AVE.</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 14 1979</b>                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE <b>Pinkney McCready</b>                                                                      |                                              |

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BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                   |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                 |                                                                                                                                    |                                                        |                                                                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   |  |                                                                                                                                                             | 7 9 1 3 7 7 2<br>REG. NO.                                                                                                                            |                                                                                 |                                                                                                                                    |                                                        |                                                                                              |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Bessie E. Odendhall</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 28 1979</b>                                                                                              |                                                                                 |                                                                                                                                    | 2b. HOUR<br><b>11:50 P.M.</b>                          |                                                                                              |  |
| 3 SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                         |  | 4 RACE<br><b>W</b>                                                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 10 94</b>                                                                                                          |                                                                                                                                                      | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>84</b> YRS                     |                                                                                                                                    | IF UNDER 1 YEAR IF UNDER 24 HRS<br>HOURS MIN.          |                                                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.              |                                                                                                                                    |                                                        |                                                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |  |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Usher--</b> |                                                                                                                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---Theater</b> |                                                                                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                  |  |                                                                                                                                                   |  |                                                                                                                                                             | 13b. COUNTY<br><b>Balto</b>                                                                                                                          |                                                                                 | 13c. CITY OR TOWN<br><b>Spring Grove Hospital 21228</b>                                                                            |                                                        | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>William H. Russell</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Jane Sterling</b>                                                                              |                                                                                 |                                                                                                                                    |                                                        |                                                                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>- no</b>                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>212-22-5124</b>                                                                                                    |  | 17 INFORMANT ADDRESS<br><b>Mr. Charles W. Cox Rt. 1 Box 89 Chester Md. 21619</b>                                                                            |                                                                                                                                                      |                                                                                 |                                                                                                                                    |                                                        |                                                                                              |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Carcinoma of the lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.    |  |                                                                                                                                                   |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                 |                                                                                                                                    |                                                        |                                                                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                 |                                                                                                                                    |                                                        |                                                                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                  |  |                                                                                                                                                             | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                    |                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                        |                                                                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                                                                      |                                                                                 |                                                                                                                                    |                                                        |                                                                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                                                                                                      |                                                                                 |                                                                                                                                    |                                                        |                                                                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/10</b> , 19 <b>79</b> , to <b>6/28</b> , 19 <b>79</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>6/28</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                   |  |                                                                                                                                                             |                                                                                                                                                      |                                                                                 |                                                                                                                                    |                                                        |                                                                                              |  |
| 22b. SIGNATURE<br><b>John E. Adams, M.D.</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |  |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                 | 22c. DATE SIGNED<br><b>6/29/79</b>                                                                                                 |                                                        |                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John E. Adams, M.D.</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  |                                                                                                                                                             | 22e. ADDRESS<br><b>6701 N. Charles St, Balto. Md. 21204</b>                                                                                          |                                                                                 |                                                                                                                                    |                                                        |                                                                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>7/3/79</b>                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>                                                                                              |                                                                                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                    |                                                                                                                                    |                                                        |                                                                                              |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Mitchell-Wiedefeld</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  | ADDRESS<br><b>6500 York Rd.</b>                                                                                                                             |                                                                                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 5 1979</b>                              |                                                                                                                                    | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>   |                                                                                              |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

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| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>James Henry O'Farrell</i>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>June 8 1979</i> |                                                                                                                                                             | 2b. HOUR<br><i>9P</i> M |                                                                                                                            |                                                                |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><i>white</i>                                                                                                                    |                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>11 7 1925</i>                                                                                                      |                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>53</i>                                                           |                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                 |                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                                                        |                                                                |
| 10. CITY OR TOWN OF DEATH<br><i>Pikesville</i>                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>4016 Raleigh Rd. 21208</i> |                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Ret- Letter Carrier</i>                                                              |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Post office</i>                                                                    |                                                                |
| 13a. STATE<br><i>Md</i>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                            |                                                        | 13b. COUNTY<br><i>Balto</i>                                                                                                                                 |                         | 13c. CITY OR TOWN<br><i>Pikesville</i>                                                                                     |                                                                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>James O'Farrell</i>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            |                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Marie Helen O'Brien</i>                                                                                 |                         |                                                                                                                            |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>yes</i>                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>WW 2</i>                                                                     |                                                        | 17. INFORMANT ADDRESS<br><i>Owings Mills, Md</i><br><i>Robert O'Farrell 11G Matinee Ct. 21117</i>                                                           |                         |                                                                                                                            |                                                                |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i><br><i>410-</i> DUE TO, OR AS A CONSEQUENCE OF <i>Coronary Heart Disease</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>2 yrs</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                                                                            |                                                        |                                                                                                                                                             |                         |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>minutes</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Parkinson's disease</i>                                                                                                                                                                                                                                      |  |                                                                                                                                            |                                                        |                                                                                                                                                             |                         |                                                                                                                            |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                 |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                         |                                                                                                                            |                                                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                         |                                                                                                                            |                                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7 March 1979</i> to <i>8 June 1979</i> , that (I) (we) last saw the deceased alive on <i>7 March 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                                                  |  |                                                                                                                                            |                                                        |                                                                                                                                                             |                         |                                                                                                                            |                                                                |
| 22b. SIGNATURE<br><i>MD</i>                                                                                                                                                                                                                                                                                                                                                                           |  | DEGREE<br><i>MD</i>                                                                                                                        |                                                        | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                         | 22c. DATE SIGNED<br><i>11 June 79</i>                                                                                      |                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Marvin Davis</i>                                                                                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS<br><i>8507 Liberty Rd. Randallstown, Md.</i>                                                                                  |                                                        |                                                                                                                                                             |                         |                                                                                                                            |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><i>6/12/1979</i>                                                                                                              |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lorraine Park</i>                                                                                                  |                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Woodlawn Baltimore Md</i>                                                 |                                                                |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Loring Byers Funeral Directors, P.A. 21133</i>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                            |                                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |                         | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia Roberts</i>                                                                      |                                                                |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                          |  | 7 9 1 3 7 7 4                                                                                                                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Sidney</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>6/7/79</b>                                                                                                    |  |
| 3. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 4 RACE <b>WHITE</b>                                                                                                                               |  |
| 5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 26, 1907</b>                                                                                                                                                                                                                                                                                                                                                            |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS                                                                                                      |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ENGLAND</b>                                                                                                                                                                                                                                                                                                                                                         |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                         |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                         |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.                                                                                   |  |
| 10 CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>   |  |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>                                                                                                                                                                                                                                                                                                                                    |  | 12b KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>                                                                                                    |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                     |  | 13b COUNTY <b>BALTIMORE</b>                                                                                                                       |  |
| 13c CITY OR TOWN <b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  |
| 14 FATHER'S NAME <b>LAZARUS</b> MIDDLE <b>ORANDLE</b>                                                                                                                                                                                                                                                                                                                                                           |  | 15 MOTHER'S MAIDEN NAME <b>RACHEL</b> FIRST <b>LOWENTHAL</b> LAST                                                                                 |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                      |  | 16b SOCIAL SECURITY NO. <b>215-10-4787</b>                                                                                                        |  |
| 17 INFORMANT <b>MRS. EVELYN ORANDLE</b>                                                                                                                                                                                                                                                                                                                                                                         |  | ADDRESS <b>3607 YENNAR LA., APT. 1B #21207</b>                                                                                                    |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b><br><b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute anterior wall MI with pulmonary</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>edema and Cardiogenic shock.</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                   |  |
| 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>                                                                                            |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                                                                                  |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                            |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                                                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-2-</b> 19 <b>79</b> , to <b>6-7-</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-7-79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                |  |                                                                                                                                                   |  |
| 22b. SIGNATURE <b>A. M. Shah</b>                                                                                                                                                                                                                                                                                                                                                                                |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. M. SHAH.</b>                                                                                          |  |
| 22e. ADDRESS <b>Baltimore county General hospital</b>                                                                                                                                                                                                                                                                                                                                                           |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                           |  |
| 23b. DATE <b>6-10-79</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BETH ISAAC ADATH ISRAEL</b>                                                                                 |  |
| 23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MD</b> STATE                                                                                                                                                                                                                                                                                                                                              |  | 24 FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>                                     |  |
| 25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>                                                                                                                                                                                                                                                                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE <b>Esther M. Brady</b>                                                                                                 |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                              |                                                                                                                                            |                                                                                      |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SIDNEY ORINGER</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>6-12-79</b>                     |                                                                                                                                                             |                                                                                                              | 2b. HOUR<br><b>1:50</b> PM                                                                                                                 |                                                                                      |                                                                                                                            |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>WHITE</b>                                                                                                                            |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>JUNE 12, 1912</b>                                                                                                     |                                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                                                                          |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                                                             |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                         |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                                                                        |                                                                                      |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSPITAL</b> |                                                                        |                                                                                                                                                             |                                                                                                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>FOREMAN</b>                                                          |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PLASTIC</b>                                                                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>FLA.</b>                                                                                                                                                                                                                                                             |  |                                                                                                                                                    | 13b. COUNTY<br><b>W. PALM BEACH</b>                                    |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>W. PALM BEACH</b>                                                                    |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAMUEL ORINGER</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EVA SEIDMAN</b>    |                                                                                                                                                             |                                                                                                              |                                                                                                                                            |                                                                                      |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br><b>050-01-5546</b>                         |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>MRS. SALLY ORINGER</b><br><b>173 LAKE EVELYN DR., W. PALM BEACH, FL 33411</b> |                                                                                                                                            |                                                                                      |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Carcinoma of lungs with metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                              |                                                                                                                                            |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>years?</b>                                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                   |  |                                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                              |                                                                                                                                            |                                                                                      |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                              |  |                                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                      |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                      |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-29-79</b> , to <b>6-12-79</b> that (I) (we) lost saw the deceased alive on <b>6-12-79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                            |  |                                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                              |                                                                                                                                            |                                                                                      |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Soonchul Hong</b> DEGREE                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                              | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                      | 22c. DATE SIGNED<br><b>6-12-79</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SOON CHUL HONG</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                              | 22e. ADDRESS<br><b>Baltimore County General Hospital</b>                                                                                   |                                                                                      |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                    | 23b. DATE<br><b>JUNE 13, 1979</b>                                      |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHEVRA AHAVAS CHESED</b>                                            |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>RANDALLSTOWN BALTO. MD</b>          |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>                                                                                                                                                                                                                                                       |  |                                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 14 1979</b>                                                                                        |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Corbally</b>                                                                    |  |

MEDICAL CERTIFICATION

21161 81

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 03-10-01 BY 60321

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 3 7 7 6

|                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                                             |                   |                                                                                                 |                                     |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                       |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                |  | FIRST<br>RACHEL                                                                                                                                             | MIDDLE<br>OUAZANA | LAST<br>JUNE 25, 1979                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR | 2b. HOUR<br>9:45 P.                                                                                                        |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>WHITE                                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN. 1, 1909                                                                                                          |                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS                                                       |                                     | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MORROCCO                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>MORROCCO                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |                                     |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1915 WESTCHESTER AVE. |  |                                                                                                                                                             |                   | 12a. USUAL OCCUPATION<br>(TYPE OR NAME OF WORKING LIFE)<br>HOUSEWIFE                            |                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME                                                                               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  |                                                                                                                                                             |                   |                                                                                                 |                                     |                                                                                                                            |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                                                        |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              |                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                     |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ALIYOHU EL KAIM                                                                                                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HABIBA BITTON                                                                     |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                      |                   |                                                                                                 |                                     |                                                                                                                            |
| 16b. SOCIAL SECURITY NO.<br>219-76-3982M                                                                                                                                                                                                                                                                                                                                           |  | 17. INFORMANT<br>HEBREW BURIAL & SOC. SERV. SOCIETY<br>1330 REISTERSTOWN RD. BALTO., MD 21208                                      |  |                                                                                                                                                             |                   |                                                                                                 |                                     |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause primary for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Chronic myelogenous leukemia in last crisis</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>2051<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                                    |  |                                                                                                                                                             |                   |                                                                                                 |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Chronic thrombocytopenia</i>                                                                                                                                                                                                               |  |                                                                                                                                    |  |                                                                                                                                                             |                   |                                                                                                 |                                     |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  |                                                                                                                                                             |                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                   |                                                                                                 |                                     |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                   |                                                                                                 |                                     |                                                                                                                            |
| 22a. I certify that (we) <i>Dr. L. Lichtenfeld</i> attended the deceased from <i>6/18/79</i> to <i>6/26/79</i> , that (I) (we) last saw the deceased alive on <i>6/18/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                                  |  |                                                                                                                                    |  |                                                                                                                                                             |                   |                                                                                                 |                                     |                                                                                                                            |
| 22b. SIGNATURE<br><i>Dr. L. Lichtenfeld</i><br>DR. L. LICHTENFELD                                                                                                                                                                                                                                                                                                                  |  | DEGREE                                                                                                                             |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                   | 22c. DATE SIGNED<br>6/26/79                                                                     |                                     |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>JUNE 27, 1979                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW                                                                                                      |                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                |                                     |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD., BALTO., MD 21215                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 3 1979                                                                                                                 |                   | 25b. REGISTRAR'S SIGNATURE<br><i>Rickie McCreedy</i>                                            |                                     |                                                                                                                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



13110

John A. ...

John A. ...

John A. ...

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                |  | 7 9 1 3 7 7 7                                                                                                                         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                         |  | 2a. DATE OF DEATH                                                                                                                     |  |
| Mary Anna PANUSKA                                                                                                                                                                                                                                                                                                                           |  | MONTH DAY YEAR 6 7 79                                                                                                                 |  |
| 3. SEX<br>FEmale                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>Caucasian                                                                                                                  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR July 19, 1894                                                                                                                                                                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                                                                                                                                                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                                                                                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                      |  | 13b. COUNTY<br>Baltimore                                                                                                              |  |
| 13c. CITY OR TOWN<br>Essex                                                                                                                                                                                                                                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 13e. STREET ADDRESS<br>917 Barron Avenue 21221                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Petr                                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Vacek                                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>215-09-1692D                                                                                              |  |
| 17. INFORMANT<br>ADDRESS<br>345 Maple Avenue<br>Balto. Md. 21221                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-respiratory arrest<br>diabetes mellitus<br>(b) Sepsis, urinary tract infection, adult onset<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                          |  |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/25/ 19 79, to 6/7/ 19 79, that (I) (we) last saw the deceased alive on 6/7/ 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                            |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br>Meher Tabatabai MD.                                                                                                                                                                                                                                                                                                       |  | 22c. DATE SIGNED<br>6/7/79                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Meher Tabatabai, M.D.                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS<br>9000 Franklin Square Drive                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br>6/11/79                                                                                                                  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.                                                                                                                                                                                                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                                                          |  |
| 24. FUNERAL DIRECTOR'S NAME<br>Scamurek Funeral Home, Inc.                                                                                                                                                                                                                                                                                  |  | 24b. ADDRESS<br>3331 Brehms Lane<br>Balto. Md. 21213                                                                                  |  |
| 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                               |  | 25b. SIGNATURE<br>P. J. Brady                                                                                                         |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |                                                                                |  |                                                                                                                            |  |                                                                                                                                     |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|
| <div> <div> <div>FOR</div> <div>1- STATE REGISTRAR</div> </div> <div> <div>Items 21a. &amp; 21f. &amp; 21g. &amp; 21h. &amp; 21i. &amp; 21j. &amp; 21k. &amp; 21l. &amp; 21m. &amp; 21n. &amp; 21o. &amp; 21p. &amp; 21q. &amp; 21r. &amp; 21s. &amp; 21t. &amp; 21u. &amp; 21v. &amp; 21w. &amp; 21x. &amp; 21y. &amp; 21z.</div> <div>Film#G533 7-16-79</div> </div> </div> <div> <div>REG. NO.</div> <div>13778</div> </div>                                             |  |  |  |                                                                                |  |                                                                                                                            |  |                                                                                                                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>PAUL LUDWIG Patzold</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |                                                                                |  | 2a. DATE KNOWN OF DEATH                                                                                                    |  | 2b. DATE OF DEATH                                                                                                                   |  |
| 3. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |                                                                                |  | 4. RACE <b>W</b>                                                                                                           |  | 5. DATE OF BIRTH                                                                                                                    |  |
| 6. AGE (IN YEARS) <b>52</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |                                                                                |  | 7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>                                                                            |  | 8. IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>                                                                                    |  |
| 9a. BIRTHPLACE (STATE OR COUNTRY) <b>Essen Germany</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |                                                                                |  | 9b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                    |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Sept</b> |  |
| 11. CITY OR TOWN OF DEATH <b>21234</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |                                                                                |  | 12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN NURSING HOME, GIVE STREET ADDRESS) <b>1816 Trenlugh Rd</b> |  | 13. USUAL OCCUPATION (TYPE OF WORK) <b>shore Bus Driver Balto Co.</b>                                                               |  |
| 14. STATE <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |                                                                                |  | 15. COUNTY <b>Balto</b>                                                                                                    |  | 16. CITY OR TOWN <b>21234</b>                                                                                                       |  |
| 17. FATHER'S NAME <b>Max Patzold</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |                                                                                |  | 18. MOTHER'S MAIDEN NAME <b>Louise Haupt</b>                                                                               |  | 19. ADDRESS <b>Cath Patzold wife 1816 Trenlugh</b>                                                                                  |  |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE BRANCH AND DATES) <b>yes, Navy, NYC Retd</b>                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |                                                                                |  | 21. SOCIAL SECURITY NO. <b>9554</b>                                                                                        |  | 22. INFORMATION <b>Cath Patzold wife 1816 Trenlugh</b>                                                                              |  |
| <div> <div>IMMEDIATE CAUSE (a) <b>Sunshot wound head</b></div> <div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.</div> <div> <div>THROUGH ROOF OF MOUTH</div> </div> </div> </div>                                                                                                                                                                                                                                   |  |  |  |                                                                                |  |                                                                                                                            |  |                                                                                                                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                                         |  |  |  |                                                                                |  |                                                                                                                            |  |                                                                                                                                     |  |
| 19a. DATE OF OPERATION <b>—</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>—</b>                     |  |                                                                                                                            |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                              |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>0405 19</b>               |  |                                                                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Gun Shot</b>                                       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Wife's home</b> |  |                                                                                                                            |  | 21f. LOCATION CITY OR TOWN <b>1816 Trenlugh Rd. Balto. Co. 21234</b> STATE <b>MD.</b>                                               |  |
| <div> <div>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion, death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>.</div> </div> |  |  |  |                                                                                |  |                                                                                                                            |  |                                                                                                                                     |  |
| ACTUAL SIGNATURE <b>Frank T. Kasik Jr</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  | TITLE (SPECIFY) <b>Asst Depy</b>                                               |  |                                                                                                                            |  | DATE SIGNED <b>6/21/79</b>                                                                                                          |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>FRANK T. KASIK JR</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  | ADDRESS <b>9005 HARTFORD Rd</b>                                                |  |                                                                                                                            |  |                                                                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  | 23b. DATE <b>June 23, '79</b>                                                  |  |                                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>                                                                        |  |
| 24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  | ADDRESS <b>8521 Loch Raven Blvd</b>                                            |  |                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1979</b>                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Fisher</b>                                       |  |                                                                                                                            |  |                                                                                                                                     |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                |                                                     |                                                                                                                                                             |  |                                                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Pauleros                                                                                                                                                                                                                                                |  |                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 13 1979 |                                                                                                                                                             |  | 2b. HOUR<br>12 noon                                                                                                           |  |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                      |  | 4. RACE<br>white                                                                                                               |                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 13 87                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.                                                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Greece                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                            |                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Reisterstown                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bent Nursing Home |                                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cook                                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Restaurants                                                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                              |  |                                                                                                                                |                                                     | 13b. COUNTY<br>Baltimore                                                                                                                                    |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                |  |
| 14. FATHER'S NAME<br>(UNKNOWN)                                                                                                                                                                                                                                                                      |  |                                                                                                                                |                                                     | 15. MOTHER'S MAIDEN NAME<br>(UNKNOWN)                                                                                                                       |  |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br>210-36-3857                                                                                        |                                                     | 17. INFORMANT<br>Helen Loewer                                                                                                                               |  |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4409<br>IMMEDIATE CAUSE (a):<br>Cardiac Failure<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b):<br>Atherosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c):                                |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH:<br>48 hours<br>Years                                                          |                                                     |                                                                                                                                                             |  |                                                                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):                                                                                                                                                                 |  |                                                                                                                                |                                                     |                                                                                                                                                             |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>21a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                               |  |
| 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                              |  | 21e. LOCATION<br>(STREET)                                                                                                      |                                                     | CITY OR TOWN                                                                                                                                                |  | COUNTY STATE                                                                                                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-10-1979 to 6-13-1979 that (I) (we) last saw the deceased alive on 6-11-1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If last (did) not view the body after death. |  |                                                                                                                                |                                                     |                                                                                                                                                             |  |                                                                                                                               |  |
| 22b. SIGNATURE<br>O.E. McWilliams                                                                                                                                                                                                                                                                   |  | DEGREE<br>MD                                                                                                                   |                                                     | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>6-13-79                                                                                                   |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>O.E. McWilliams                                                                                                                                                                                                                                            |  | 23b. ADDRESS<br>11904 Reisterstown Rd Reisterstown Md 21138                                                                    |                                                     |                                                                                                                                                             |  |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                              |  | 23b. DATE<br>June 15/79                                                                                                        |                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br>Greek Orthodox                                                                                                        |  | 23d. LOCATION<br>CITY OR TOWN<br>Baltimore                                                                                    |  |
| COUNTY<br>Maryland                                                                                                                                                                                                                                                                                  |  | STATE                                                                                                                          |                                                     |                                                                                                                                                             |  |                                                                                                                               |  |

24. FUNERAL DIRECTOR  
ROBERT C. ALTENBURG FUNERAL HOME, INC.  
6009 Harford Rd. - Baltimore, Md. 21214

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JUN 14 1979

Patricia McBrady



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 13780

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                           |                                                                                |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |                                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CLARENCE N. PEARCE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 10 1979</b>                     |                                                                                                                                                             |                                                                                | 2b. HOUR<br><b>1 a.m.</b>                                                            |                                                                                                 |                                                                                                                            |                                                              |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>White</b>                                                                                                                   |                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 8, 1899</b>                                                                                                   |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                    |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |                                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD                   |                                                                                                 |                                                                                                                            |                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SAINT JOSEPH HOSPITAL</b> |                                                                                |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Building</b>                                                                       |                                                              |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           | 13b. COUNTY<br><b>Balto.</b>                                                   |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Parkton</b>                                            |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            |                                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Silas Pearce</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie Wilson</b>          |                                                                                                                                                             |                                                                                | 16. STREET ADDRESS<br><b>17030 York Road</b>                                         |                                                                                                 |                                                                                                                            |                                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-01-0122</b>  |                                                                                                                                                             | 17. INFORMANT<br><b>Donald Pearce</b>                                          |                                                                                      |                                                                                                 |                                                                                                                            | ADDRESS<br><b>922 Mt. Carmel Road<br/>Parkton, Md. 21120</b> |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>pneumonia</b><br>4392<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <b>arteriosclerotic Cardiovascular disease</b><br>(c) <b>Chronic Organic Brain Syndrome</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Organic Brain Syndrome</b> |  |                                                                                                                                           |                                                                                |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b> |  |
| 19a. DATE OF OPERATION<br><b>JUNE 4, 1979</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>FEEDING GASTROSTOMY</b> |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                     |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                      |                                                                                                 |                                                                                                                            |                                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                      |                                                                                                 |                                                                                                                            |                                                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MAY 24</b> 19 <b>79</b> , to <b>JUNE 10</b> 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>JUNE 10</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.                                                                                                      |  |                                                                                                                                           |                                                                                |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            | 22b. SIGNATURE<br><b>Mark S. Kaplan MD</b>                   |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARK S. KAPLAN MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           | 22d. ADDRESS<br><b>16918 MONKTON</b>                                           |                                                                                                                                                             |                                                                                | 22e. DATE SIGNED<br><b>6/11/79</b>                                                   |                                                                                                 |                                                                                                                            |                                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                           | 23b. DATE<br><b>June 12 1979</b>                                               |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>West Liberty Cem.</b>                 |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>White Hall, Balto., Md.</b>                    |                                                                                                                            |                                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. J. Hartenstein</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           | ADDRESS<br><b>New Freedom, Pa.</b>                                             |                                                                                                                                                             |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>                                  |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCready</b>                                                                      |                                                              |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                              |                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                               | 2b. HOUR                                                                                     |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                      |                                                                                                        | MONTH DAY YEAR                                                                                                                                           |                                                               | P M                                                                                          |                                   |
| CRAVEN P. PEARSON                                                                                                                                                                                                                                                                                     |                                                                                                        | 6 16 79                                                                                                                                                  |                                                               | 5:20 P                                                                                       |                                   |
| 3. SEX                                                                                                                                                                                                                                                                                                | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                               | 7. IF UNDER 1 YEAR                                                                           |                                   |
| Male                                                                                                                                                                                                                                                                                                  | White                                                                                                  | MONTH DAY YEAR                                                                                                                                           | 64                                                            | MONTHS DAYS HOURS MIN                                                                        |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                                                                                              |                                   |
| Maryland                                                                                                                                                                                                                                                                                              | USA                                                                                                    |                                                                                                                                                          | Baltimore County MD.                                          |                                                                                              |                                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY |
| Randallstown                                                                                                                                                                                                                                                                                          | Baltimore County General                                                                               |                                                                                                                                                          | Vice President                                                |                                                                                              | Insurance                         |
| 13a. STATE                                                                                                                                                                                                                                                                                            |                                                                                                        | 13b. COUNTY                                                                                                                                              | 13c. CITY OR TOWN                                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |
| Md                                                                                                                                                                                                                                                                                                    |                                                                                                        | Carroll                                                                                                                                                  | Sykesville                                                    | 6920 Stratford Drive                                                                         |                                   |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                     |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                               |                                                                                              |                                   |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                     |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |                                                               |                                                                                              |                                   |
| Craven P. Pearson, Sr.                                                                                                                                                                                                                                                                                |                                                                                                        | Mary Elizabeth Bauman                                                                                                                                    |                                                               |                                                                                              |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                     |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                 | 17. INFORMANT ADDRESS                                         |                                                                                              |                                   |
| Yes                                                                                                                                                                                                                                                                                                   |                                                                                                        | WW2                                                                                                                                                      | Mrs. Mary Catherine Pearson Same as #13                       |                                                                                              |                                   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                              |                                   |
| IMMEDIATE CAUSE (a) myocardial infarct                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                              |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                              |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c) hypertension                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                              |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) diabetes mellitus                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                              |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                               | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                    |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                               | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-20-79 to 6-16-79, that (I) (we) last saw the deceased alive on 6-16-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                              |                                   |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                        |                                                                                                        | DEGREE                                                                                                                                                   |                                                               | 22c. DATE SIGNED                                                                             |                                   |
| M Peksa                                                                                                                                                                                                                                                                                               |                                                                                                        | MD                                                                                                                                                       |                                                               | 6-16-79                                                                                      |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                 |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                               |                                                                                              |                                   |
| M Peksa                                                                                                                                                                                                                                                                                               |                                                                                                        | Bath Cty Gen'l Hosp                                                                                                                                      |                                                               |                                                                                              |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                             |                                                                                                        | 23b. DATE                                                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY                            | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                      |                                   |
| Burial                                                                                                                                                                                                                                                                                                |                                                                                                        | 6/20/79                                                                                                                                                  | Oaklawn Cemetery                                              | Baltimore Md                                                                                 |                                   |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR                                 |                                                                                              | 25b. REGISTRAR'S SIGNATURE        |
| Witzke Funeral Home of Catonsville                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          | JUN 20 1979                                                   |                                                                                              | History McCreedy                  |
| 1630 Edmondson Avenue Catonsville, Md.                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                              |                                   |

10001



LIBRARY OF CONGRESS

WINDY HILL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13782

|                                                                                                                                                                                                                                                                                                                  |         |                                                                                                        |                  |                                                                                                                                                          |                                 |                                                                     |                 |                                                 |                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------|-----------------|-------------------------------------------------|-----------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                              |         | FIRST                                                                                                  | MIDDLE           | LAST                                                                                                                                                     | 2a. DATE OF DEATH               | MONTH                                                               | DAY             | YEAR                                            | 2b. HOUR        |
| ELSIE MARIE PEDDICORD                                                                                                                                                                                                                                                                                            |         |                                                                                                        |                  |                                                                                                                                                          | 6                               | 22                                                                  | 79              |                                                 | 11:50 PM        |
| 3. SEX                                                                                                                                                                                                                                                                                                           | 4. RACE |                                                                                                        | 5. DATE OF BIRTH |                                                                                                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY) |                                                                     | IF UNDER 1 YEAR |                                                 | IF UNDER 24 HRS |
| FEMALE                                                                                                                                                                                                                                                                                                           | WHITE   |                                                                                                        | SEPT. 30, 1892   |                                                                                                                                                          | 86                              |                                                                     | MONTHS          |                                                 | DAYS            |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                        |         | 7c. CITIZEN OF WHAT COUNTRY?                                                                           |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                 | MD.                                             |                 |
| MARYLAND                                                                                                                                                                                                                                                                                                         |         | USA                                                                                                    |                  |                                                                                                                                                          |                                 | BALTIMORE                                                           |                 |                                                 |                 |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                        |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                 |                                                 |                 |
| TOWSON                                                                                                                                                                                                                                                                                                           |         | GREATER BALTO. MEDICAL CENTER                                                                          |                  | HOUSEWIFE                                                                                                                                                |                                 | HOME                                                                |                 |                                                 |                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                     |         | 13b. COUNTY                                                                                            |                  | 13c. CITY OR TOWN                                                                                                                                        |                                 | 13d. INSIDE CITY LIMITS?                                            |                 | 13e. STREET ADDRESS                             |                 |
| MARYLAND                                                                                                                                                                                                                                                                                                         |         | ANNE ARUNDEL                                                                                           |                  | ANNAPOLIS                                                                                                                                                |                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                 | 62 MAYLAND AVE.                                 |                 |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                |         | 15. MOTHER'S MAIDEN NAME                                                                               |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |                                 | 16b. SOCIAL SECURITY NO.                                            |                 | 17. INFORMANT ADDRESS                           |                 |
| GEORGE HENRY SCHMITT                                                                                                                                                                                                                                                                                             |         | EMMA L. WIENEKE                                                                                        |                  | NO                                                                                                                                                       |                                 | 214-50-8713                                                         |                 | MARYLAND MASONIC HOMES, INC. COCKEYESVILLE, MD. |                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                            |         | IMMEDIATE CAUSE (a)                                                                                    |                  | PULMONARY EDEMA                                                                                                                                          |                                 | DUE TO, OR AS A CONSEQUENCE OF                                      |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |                 |
| 514-                                                                                                                                                                                                                                                                                                             |         |                                                                                                        |                  |                                                                                                                                                          |                                 |                                                                     |                 |                                                 |                 |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                                                                                                                   |         | (b)                                                                                                    |                  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                           |                                 | (c)                                                                 |                 |                                                 |                 |
|                                                                                                                                                                                                                                                                                                                  |         |                                                                                                        |                  |                                                                                                                                                          |                                 |                                                                     |                 |                                                 |                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                               |         |                                                                                                        |                  |                                                                                                                                                          |                                 |                                                                     |                 |                                                 |                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                           |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                  | 20a. AUTOPSY?                                                                                                                                            |                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                 |                                                 |                 |
|                                                                                                                                                                                                                                                                                                                  |         |                                                                                                        |                  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |                                 | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                 |                                                 |                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                               |         | 21b. TIME OF INJURY                                                                                    |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                 |                                                                     |                 |                                                 |                 |
|                                                                                                                                                                                                                                                                                                                  |         | HOUR A.M. MONTH DAY YEAR                                                                               |                  |                                                                                                                                                          |                                 |                                                                     |                 |                                                 |                 |
|                                                                                                                                                                                                                                                                                                                  |         | P.M. 19                                                                                                |                  |                                                                                                                                                          |                                 |                                                                     |                 |                                                 |                 |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                             |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                  | 21f. LOCATION                                                                                                                                            |                                 | CITY OR TOWN                                                        |                 | COUNTY STATE                                    |                 |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                |         |                                                                                                        |                  | STREET                                                                                                                                                   |                                 |                                                                     |                 |                                                 |                 |
|                                                                                                                                                                                                                                                                                                                  |         |                                                                                                        |                  |                                                                                                                                                          |                                 |                                                                     |                 |                                                 |                 |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 22, 1979, to JUNE 22, 1979, that (we) lost saw the deceased alive on JUNE 22, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |         |                                                                                                        |                  |                                                                                                                                                          |                                 |                                                                     |                 |                                                 |                 |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                   |         | DEGREE                                                                                                 |                  | 22c. DATE SIGNED                                                                                                                                         |                                 |                                                                     |                 |                                                 |                 |
| Dr. Rick Chasen                                                                                                                                                                                                                                                                                                  |         |                                                                                                        |                  | 6/23/79                                                                                                                                                  |                                 |                                                                     |                 |                                                 |                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                            |         | 22e. ADDRESS                                                                                           |                  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |                                 |                                                                     |                 |                                                 |                 |
| DR. RICK CHASEN                                                                                                                                                                                                                                                                                                  |         | 6701 NORTH CHARLES ST. 21204                                                                           |                  |                                                                                                                                                          |                                 |                                                                     |                 |                                                 |                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                        |         | 23b. DATE                                                                                              |                  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                 | 23d. LOCATION                                                       |                 | COUNTY STATE                                    |                 |
| BURIAL                                                                                                                                                                                                                                                                                                           |         | JUNE 25, 1979                                                                                          |                  | WESTERN                                                                                                                                                  |                                 | BALTIMORE CITY, MARYLAND                                            |                 |                                                 |                 |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                             |         | 25a. DATE REC'D. BY REGISTRAR                                                                          |                  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |                                 |                                                                     |                 |                                                 |                 |
| MITCHELL-WIEDEFELD HOME, INC. 6500 YORK RD. BALTIMORE, MD. 21212                                                                                                                                                                                                                                                 |         | JUN 28 1979                                                                                            |                  | [Signature]                                                                                                                                              |                                 |                                                                     |                 |                                                 |                 |

BP

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BALTIMORE

MONTGOMERY

TOWSON

ALBANY COUNTY

JUNE 22 1964

JUNE 22

X

DR. PINK CHERRY 100% MOUTH GUARDS 21. 2124



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                  |  |                                                                                                                                  |                                                                     |                                                                                                                                                            |                                                                        |                                                                                                                                           |                                                                      |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                |  |                                                                                                                                  |                                                                     |                                                                                                                                                            |                                                                        |                                                                                                                                           |                                                                      |                                                                                                                         |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Eliza OR BETTY P. Perrera</b>                                                                                                                                                                                                                                 |  |                                                                                                                                  |                                                                     |                                                                                                                                                            |                                                                        | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 29, 1979</b>                                                                                  |                                                                      | 2b. HOUR a<br><b>2:25 M</b>                                                                                             |  |
| 3 SEX<br><b>F.</b>                                                                                                                                                                                                                                                                                                    |  | 4 RACE<br><b>W.</b>                                                                                                              |                                                                     | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>6/5/19</b>                                                                                                            |                                                                        | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>60 Yrs.</b>                                                                              |                                                                      | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>IOWA</b>                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                    |                                                                     | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                        | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                                        |                                                                      |                                                                                                                         |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO.</b>                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE</b> |                                                                     |                                                                                                                                                            |                                                                        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PHOTO.</b>                                                            |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PHOTO.</b>                                                                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                               |  |                                                                                                                                  |                                                                     |                                                                                                                                                            |                                                                        |                                                                                                                                           |                                                                      |                                                                                                                         |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>BALTO.</b>                                                                                                     |                                                                     | 13c. CITY OR TOWN<br><b>REISTERSTOWN</b>                                                                                                                   |                                                                        | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                              |                                                                      | 13e. STREET ADDRESS<br><b>26 EWING DR.</b>                                                                              |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>JAMES LANG</b>                                                                                                                                                                                                                                                               |  |                                                                                                                                  |                                                                     |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>???</b>                |                                                                                                                                           |                                                                      |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                        |  |                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br><b>212-18-3512</b>                      |                                                                                                                                                            | 17 INFORMANT ADDRESS<br><b>MR. ANGELO PERRERA 7822 ST. CLAIRE LANE</b> |                                                                                                                                           |                                                                      |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                              |  |                                                                                                                                  |                                                                     |                                                                                                                                                            |                                                                        |                                                                                                                                           |                                                                      |                                                                                                                         |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Exacerbation of Chronic Obstructive Pulmonary Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cor Pulmonale</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                   |  |                                                                                                                                  |                                                                     |                                                                                                                                                            |                                                                        |                                                                                                                                           |                                                                      |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):                                                                                                                                                                                  |  |                                                                                                                                  |                                                                     |                                                                                                                                                            |                                                                        |                                                                                                                                           |                                                                      |                                                                                                                         |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |                                                                     |                                                                                                                                                            |                                                                        |                                                                                                                                           |                                                                      |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                |  |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                            |                                                                        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                         |                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  |                                                                                                                                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                            |                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                            |                                                                      |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                |  |                                                                                                                                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            |                                                                        | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                            |                                                                      |                                                                                                                         |  |
| 22a. I certify that (this hospital) attended the deceased from <b>June 22, 1979</b> to <b>June 29, 1979</b> , that (we) lost the deceased alive on <b>June 29, 1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. |  |                                                                                                                                  |                                                                     |                                                                                                                                                            |                                                                        |                                                                                                                                           |                                                                      |                                                                                                                         |  |
| 22b. SIGNATURE<br><b>Neena Rao</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |                                                                     |                                                                                                                                                            |                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                      | 22c. DATE SIGNED                                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Neena Rao</b>                                                                                                                                                                                                                                                             |  |                                                                                                                                  |                                                                     |                                                                                                                                                            |                                                                        | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>                                                                                   |                                                                      |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                            |  |                                                                                                                                  | 23b. DATE<br><b>7/2/79</b>                                          |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE DORSEY</b>        |                                                                                                                                           | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. WASH. BLVD.</b> |                                                                                                                         |  |
| 24 FUNERAL DIRECTOR<br><b>DEBILA NOCE &amp; SONS 322 S. HIGH ST.</b>                                                                                                                                                                                                                                                  |  |                                                                                                                                  |                                                                     |                                                                                                                                                            |                                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 6 1979</b>                                                                                        |                                                                      | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                        |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked (c), item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                                                                    |                                                                         |                                                                                       |                                       |                                                                                                                            |                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>REGISTERAR                                                                                                                                                                                                                                                                                                                                                                             |  | REG. NO. 79 13784                                                                                                                          |  |                                                                                                                                                                    |                                                                         |                                                                                       |                                       |                                                                                                                            |                                                                                                 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA M. PETERKA</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                            |  |                                                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 18 79</b>                   |                                                                                       |                                       | 2b. HOUR<br><b>10<sup>40</sup> A M</b>                                                                                     |                                                                                                 |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>Caucasian</b>                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 2, 1896</b>                                                                                                           |                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                                     |                                       | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |                                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                  |                                       |                                                                                                                            |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Perring Pkwy Nsg. Home</b> |  |                                                                                                                                                                    |                                                                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b> |                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Schloss Bros</b>                                                                   |                                                                                                 |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |  |                                                                                                                                                                    | 13b. COUNTY<br><b>-</b>                                                 |                                                                                       | 13c. CITY OR TOWN<br><b>Baltimore</b> |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Peterka</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            |  |                                                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marie Velenosky</b> |                                                                                       |                                       |                                                                                                                            |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>                                                                        |  | 17. INFORMANT<br><b>Joseph Peterka</b>                                                                                                                             |                                                                         | ADDRESS<br><b>1319 Charmuth Road<br/>Lutherville, Md. 21093</b>                       |                                       |                                                                                                                            |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C.V.A.</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>AS CVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic arteriosclerosis.</b> |  |                                                                                                                                            |  |                                                                                                                                                                    |                                                                         |                                                                                       |                                       |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                                                                    |                                                                         |                                                                                       |                                       |                                                                                                                            |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  |                                                                                                                                                                    |                                                                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2 14 77</b><br>P.M.                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                                                                                     |                                                                         |                                                                                       |                                       |                                                                                                                            |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>6118 1/2 1977 to 6/18/79</b>                                                                               |                                                                         |                                                                                       |                                       |                                                                                                                            |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |  |                                                                                                                                                                    |                                                                         |                                                                                       |                                       |                                                                                                                            |                                                                                                 |  |
| 22b. SIGNATURE<br><b>Anthony F. Carozza</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            |  | DEGREE<br><b>MD.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                         |                                                                                       |                                       | 22c. DATE SIGNED<br><b>6/18/79</b>                                                                                         |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Anthony F. Carozza</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                            |  | 22e. ADDRESS<br><b>1801 West North Rd. Backs Md.</b>                                                                                                               |                                                                         |                                                                                       |                                       |                                                                                                                            |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><b>6/21/79</b>                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>                                                                                                    |                                                                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                   |                                       |                                                                                                                            |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SCHIMONEK FUNERAL HOME</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |  | ADDRESS<br><b>5331 BRENNIS LANE</b>                                                                                                                                |                                                                         | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>                                   |                                       | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony F. Carozza</b>                                                                    |                                                                                                 |  |

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FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

|          |                |           |                |
|----------|----------------|-----------|----------------|
| DATE     | 10/12/54       | TO        | SA [illegible] |
| FROM     | SA [illegible] | SUBJECT   | [illegible]    |
| RE       | [illegible]    | REFERENCE | [illegible]    |
| COMMENTS | [illegible]    |           |                |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13785

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 2a. DATE OF DEATH                                                                                         |  | 2b. HOUR                                                                                                                                                    |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 3. SEX                                                                                                    |  | 4. RACE                                                                                                                                                     |  |
| JOSEPH B. PFEIFFER                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Male                                                                                                      |  | Caucasian                                                                                                                                                   |  |
| 5. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                           |  | 7. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                        |  |
| 31, YEAR<br>MONTH DAY<br>January 30, 1900                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 79 YRS                                                                                                    |  | Baltimore County, MD                                                                                                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | U.S.A.                                                                                                    |  |                                                                                                                                                             |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  |
| Towson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | Greater Baltimore Medical Center                                                                          |  | Self-Employed                                                                                                                                               |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                           |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | Baltimore                                                                                                 |  | Towson                                                                                                                                                      |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME                                                                                  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                        |  |
| George Edward Pfeiffer                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | Belle Bowersox                                                                                            |  | No                                                                                                                                                          |  |
| 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 17. INFORMANT                                                                                             |  | ADDRESS                                                                                                                                                     |  |
| 215-32-1326                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | Mrs. Frances P. Miller                                                                                    |  | 408 N. Chapelgate Lane                                                                                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic obstructive pulmonary disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Arteriosclerotic cardiovascular disease</u> |  |                                                                                                           |  |                                                                                                                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20a. AUTOPSY?                                                                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 6</u> , 19 <u>79</u> , to <u>June 16</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>June 16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                           |  |                                                                                                           |  |                                                                                                                                                             |  |
| 22b. SIGNATURE<br><i>R. Breitenacker</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | DEGREE                                                                                                    |  | 22c. DATE SIGNED                                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS                                                                                              |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |
| Rudiger Breitenacker, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 6701 N. Charles Street, Balto., Md. 21204                                                                 |  | 6/17/79                                                                                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | June 19, 1979                                                                                             |  | Parkwood Cemetery                                                                                                                                           |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR                                                                             |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |  |
| Ruck Towson Funeral Home, Inc. Towson, Md. 21204                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | JUN 19 1979                                                                                               |  | <i>Anthony McCready</i>                                                                                                                                     |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |                                                                     |                                                                                                                                                             |                                                                                                                                                               |                                                                                   |                                                                                              |                                                                                                                         |                                                     |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |                                                                     |                                                                                                                                                             | 7 9 1 3 7 8 6<br>REG. NO.                                                                                                                                     |                                                                                   |                                                                                              |                                                                                                                         |                                                     |                                              |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>BERTHA I. PHILLIPS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 25, 1979</b>                                                                                                      |                                                                                   |                                                                                              |                                                                                                                         |                                                     | 2b. HOUR<br><b>9:00 a.m.</b>                 |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>white</b>                                                                                                                |                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>July 21 1914</b>                                                                                                      |                                                                                                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                 |                                                                                              | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                          |                                                     | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>               |                                                                                              |                                                                                                                         |                                                     |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SAINT JOSEPH HOSPITAL</b> |                                                                     |                                                                                                                                                             |                                                                                                                                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Assembler</b> |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tool mg</b>                                                                     |                                                     |                                              |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        | 13b. COUNTY<br><b>Baltimore</b>                                     |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Parkton</b>                                                                                                                           |                                                                                   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                         | 13e. STREET ADDRESS<br><b>1807 Mt. Carmel Road.</b> |                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>E. Wheeler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Jane Young</b>                                                                                          |                                                                                   |                                                                                              |                                                                                                                         |                                                     |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><b>230-01-6089</b>                                                                                         |                                                                     | 17. INFORMANT ADDRESS<br><b>Hensel L. Phillips 1807 Mt. Carmel Road, Parkton Md. 21120</b>                                                                  |                                                                                                                                                               |                                                                                   |                                                                                              |                                                                                                                         |                                                     |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>410- Acute anterior myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardiac arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) _____                                                                                                                                                                                            |  |                                                                                                                                        |                                                                     |                                                                                                                                                             |                                                                                                                                                               |                                                                                   |                                                                                              |                                                                                                                         |                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                                     |                                                                                                                                                             |                                                                                                                                                               |                                                                                   |                                                                                              |                                                                                                                         |                                                     |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                             |                                                                                                                                                               | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                     |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                                                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |                                                                                              |                                                                                                                         |                                                     |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                                                                                               | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |                                                                                              |                                                                                                                         |                                                     |                                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 23</b> , 19 <b>79</b> , to <b>June 25</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>June 25</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death. |  |                                                                                                                                        |                                                                     |                                                                                                                                                             |                                                                                                                                                               |                                                                                   |                                                                                              |                                                                                                                         |                                                     |                                              |  |
| 22b. SIGNATURE<br><b>Lester A. Wall, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                                     |                                                                                                                                                             | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                   |                                                                                              |                                                                                                                         |                                                     | 22c. DATE SIGNED<br><b>June 25, 1979</b>     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lester A. Wall, Jr., M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                                     |                                                                                                                                                             | 22e. ADDRESS<br><b>7620 York Road, Towson, MD 21204</b>                                                                                                       |                                                                                   |                                                                                              |                                                                                                                         |                                                     |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        | 23b. DATE<br><b>June 28, 1979</b>                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Delaney Valley Mem. Cntr.</b>                                                                                        |                                                                                   |                                                                                              | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Cockeysville Balt. Md.</b>                                                |                                                     |                                              |  |
| 24. FUNERAL DIRECTOR NAME<br><b>James J. Hester</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |                                                                     |                                                                                                                                                             | ADDRESS<br><b>24 Spring St New Rochelle, N.Y. 10801</b>                                                                                                       |                                                                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 2 1979</b>                                           |                                                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b> |                                              |  |

13180





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                    |  |                                                                                                        |        |                                                                                                                                                          |                   |                                                                     |       |                                                                                                                                                          |       |                    |   |
|----------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------------------------------------------------------------|-------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                |  | FIRST                                                                                                  | MIDDLE | LAST                                                                                                                                                     | 2a. DATE OF DEATH |                                                                     | MONTH | DAY                                                                                                                                                      | YEAR  | 2b. HOUR           |   |
| HELEN                                                                                                                                              |  | A.                                                                                                     |        | PONTON                                                                                                                                                   | 06                |                                                                     | 18    | 79                                                                                                                                                       | 9:48P |                    | M |
| 3. SEX                                                                                                                                             |  | 4. RACE                                                                                                |        | 5. DATE OF BIRTH                                                                                                                                         |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |       | IF UNDER 1 YEAR                                                                                                                                          |       | IF UNDER 24 HRS    |   |
| Female                                                                                                                                             |  | White                                                                                                  |        | 5/25/1928                                                                                                                                                |                   | 51                                                                  |       | YRS.                                                                                                                                                     |       | MONTHS             |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |       |                                                                                                                                                          |       |                    |   |
| Maryland                                                                                                                                           |  | U.S.A.                                                                                                 |        |                                                                                                                                                          |                   | TOWSON (Balto. Co.)                                                 |       | MD.                                                                                                                                                      |       |                    |   |
| 10. CITY OR TOWN OF DEATH                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |       |                                                                                                                                                          |       |                    |   |
| TOWSON<br>BALTIMORE                                                                                                                                |  | 6701 N. CHARLES STREET                                                                                 |        | Supervisor                                                                                                                                               |                   | Data Proc.                                                          |       |                                                                                                                                                          |       |                    |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                       |  | 13b. STATE                                                                                             |        | 13c. CITY OR TOWN                                                                                                                                        |                   | 13d. INSIDE CITY LIMITS?                                            |       | 13e. STREET ADDRESS                                                                                                                                      |       |                    |   |
| Maryland                                                                                                                                           |  | Balto.                                                                                                 |        | Parkville                                                                                                                                                |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       | 3327 Acton Rd.                                                                                                                                           |       | 21234              |   |
| 14. FATHER'S NAME                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME                                                                               |        |                                                                                                                                                          |                   |                                                                     |       |                                                                                                                                                          |       |                    |   |
| (Unk.)                                                                                                                                             |  | Harrington                                                                                             |        | UNKNOWN                                                                                                                                                  |                   |                                                                     |       |                                                                                                                                                          |       |                    |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                  |  | 16b. SOCIAL SECURITY NO.                                                                               |        | 17. INFORMANT                                                                                                                                            |                   | ADDRESS                                                             |       |                                                                                                                                                          |       |                    |   |
| No                                                                                                                                                 |  | 212.22.3142                                                                                            |        | Darryl R. Ponton                                                                                                                                         |                   | Balto., Md.                                                         |       | 21234                                                                                                                                                    |       | 1735 White Oak Ave |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                              |  | IMMEDIATE CAUSE (a)                                                                                    |        | CARDIOPULMONARY ARREST                                                                                                                                   |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |       |                                                                                                                                                          |       |                    |   |
| 1749                                                                                                                                               |  | DUE TO, OR AS A CONSEQUENCE OF                                                                         |        | METASTATIC BREAST CANCER                                                                                                                                 |                   | 2 MONTHS                                                            |       |                                                                                                                                                          |       |                    |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                     |  | (b)                                                                                                    |        | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                           |                   | (c)                                                                 |       |                                                                                                                                                          |       |                    |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |  |                                                                                                        |        |                                                                                                                                                          |                   |                                                                     |       |                                                                                                                                                          |       |                    |   |
| 19a. DATE OF OPERATION                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |        | 20a. AUTOPSY?                                                                                                                                            |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |       |                                                                                                                                                          |       |                    |   |
|                                                                                                                                                    |  |                                                                                                        |        | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |       |                                                                                                                                                          |       |                    |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY                                                                                    |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                   |                                                                     |       |                                                                                                                                                          |       |                    |   |
|                                                                                                                                                    |  | HOUR A.M. MONTH DAY YEAR                                                                               |        |                                                                                                                                                          |                   |                                                                     |       |                                                                                                                                                          |       |                    |   |
|                                                                                                                                                    |  | P.M. 19                                                                                                |        |                                                                                                                                                          |                   |                                                                     |       |                                                                                                                                                          |       |                    |   |
| 21d. INJURY OCCURRED                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION                                                                                                                                            |                   | CITY OR TOWN                                                        |       | COUNTY                                                                                                                                                   |       | STATE              |   |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                  |  |                                                                                                        |        | STREET                                                                                                                                                   |                   |                                                                     |       |                                                                                                                                                          |       |                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from                                                                                 |  | 06/18                                                                                                  |        | 19                                                                                                                                                       |                   | 79                                                                  |       | to                                                                                                                                                       |       | 06/18              |   |
| saw the deceased alive on                                                                                                                          |  | 06/18                                                                                                  |        | 19                                                                                                                                                       |                   | 79                                                                  |       | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |       |                    |   |
| 22b. SIGNATURE                                                                                                                                     |  | DEGREE                                                                                                 |        | 22c. DATE SIGNED                                                                                                                                         |                   |                                                                     |       |                                                                                                                                                          |       |                    |   |
| Te-h-ching Wang                                                                                                                                    |  |                                                                                                        |        | 06/18/79                                                                                                                                                 |                   |                                                                     |       |                                                                                                                                                          |       |                    |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                              |  | 22e. ADDRESS                                                                                           |        |                                                                                                                                                          |                   |                                                                     |       |                                                                                                                                                          |       |                    |   |
| DR. TEH-CHING WANG                                                                                                                                 |  | GREATER BALTIMORE MEDICAL CENTER                                                                       |        |                                                                                                                                                          |                   |                                                                     |       |                                                                                                                                                          |       |                    |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                          |  | 23b. DATE                                                                                              |        | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                   | 23d. LOCATION                                                       |       | COUNTY                                                                                                                                                   |       | STATE              |   |
| Cremation                                                                                                                                          |  | 6/20/1979                                                                                              |        | Cedar Hill                                                                                                                                               |                   | Suitland                                                            |       | Maryland                                                                                                                                                 |       |                    |   |
| 24. FUNERAL DIRECTOR                                                                                                                               |  | NAME                                                                                                   |        | ADDRESS                                                                                                                                                  |                   | 25a. DATE REC'D. BY REGISTRAR                                       |       | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |       |                    |   |
| Walter Brooks Bradley Inc.                                                                                                                         |  | Balto., Md.                                                                                            |        |                                                                                                                                                          |                   | JUN 21 1979                                                         |       | P. H. H. H. H.                                                                                                                                           |       |                    |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                      |  | 7 9 1 3 7 8 8                                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| FOR<br>1 - STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                           |  | REG. NO.                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                      |  |                                                                                                                               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Walter Roy Pool</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |  |                                                                                                                                                             |  | 2a. DATE OF DEATH                                                                               |  | MONTH <b>6</b> DAY <b>20</b> YEAR <b>79</b>                                          |  | 2b. HOUR <b>6:35</b> P.M.                                                                                                     |  |
| 3 SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                    |  | 4 RACE<br><b>white</b>                                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH <b>Sept.</b> DAY <b>29</b> YEAR <b>1880</b>                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>98</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                       |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b>                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                                    |  |                                                                                      |  |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Chapel Hill Con. Home</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Farmer</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>                                  |  |                                                                                                                               |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY<br><b>Carroll</b>                                                                                                             |  | 13c. CITY OR TOWN<br><b>Finksburg</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3935 Sykesville Road</b>                                   |  |                                                                                                                               |  |
| 14. FATHER'S NAME<br>FIRST <b>Paton</b> MIDDLE <b></b> LAST <b>Pool</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Maryetta</b> MIDDLE <b></b> LAST <b>Shipley</b>                                                                        |  |                                                                                                 |  |                                                                                      |  |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><b>213 38 6508</b>                                                                                                              |  | 17. INFORMANT<br>ADDRESS<br><b>Howard B. Pool Same as # 13</b>                                  |  |                                                                                      |  |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAL DECOMPE SATION</b><br><b>4392</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIO SCLEROTIC CV. DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                                                             |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>HOURS</b><br><b>YEARS</b>                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                     |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                      |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                |  |                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |                                                                                      |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                            |  |                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                      |  |                                                                                                                               |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>5/29</b> , 19 <b>79</b> , to <b>6/20</b> , 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6/20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Martin E. Stroibel</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>6/20/79</b>                                                   |  |                                                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARTIN E. STROIBEL M.D.</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           |  | 22e. ADDRESS<br><b>REISTERSTOWN MD</b>                                                                                                                      |  |                                                                                                 |  |                                                                                      |  |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>6/23/1979</b>                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bethesda Cemetery</b>                                                                                              |  |                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN <b>Gist</b> COUNTY <b>Carroll</b> STATE <b>Md.</b>     |  |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Thomas D. Fletcher &amp; Son Funeral Home</b> ADDRESS <b>254 E. Main St. Westminster Md.</b>                                                                                                                                                                                                                                            |  |                                                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 28 1979</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>Dorothy McCreedy</b>                                           |  |                                                                                      |  |                                                                                                                               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                               |                                                                           |                                                                  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| FOR<br>1. STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | REG. NO. 7 9 1 3 7 8 9                                                                                                                               |                                                                               |                                                                           |                                                                  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Amelia R. POREMSKI                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 28, 1979                                                                                                    |                                                                               |                                                                           | 2b. HOUR<br>6:40P M                                              |                                                                                                                            |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>WHITE                                                                                                                      |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 27, 1909                                                                                                          |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.                                    |                                                                           | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S. A                                                                                                |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |                                                                           |                                                                  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO. CO.                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |                                                                        |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME                        |                                                                                                                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | 13b. COUNTY<br>BALTO                                                                                                                                 |                                                                               | 13c. CITY OR TOWN<br>BALTO                                                |                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HENRY A. JANKIEWICZ                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LENA SPIGCH                                                                                         |                                                                               |                                                                           |                                                                  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>213-70-4998                                                                                               |                                                                        | 17. INFORMANT<br>BERNARD POREMSKI                                                                                                                           |                                                                                                                                                      | ADDRESS<br>8102 ROSEBANK AVE 21222                                            |                                                                           |                                                                  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory Arrest<br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>Left Hemispheric Cerebrovascular Accident<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                               |                                                                           |                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                          |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                               |                                                                           |                                                                  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                                      |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                     |  |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                               |                                                                           |                                                                  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                               |                                                                           |                                                                  |                                                                                                                            |  |
| 22a. I certify that X (this hospital) attended the deceased from June 26, 1979, to June 28, 1979, that X (we) last saw the deceased alive on June 28, 1979, and that in X (our) opinion death occurred on the date and hour and from the causes stated above. X (we) did (did not) examine the body of the deceased.                                                                         |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                               |                                                                           |                                                                  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Lisa Chow MD.                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                               |                                                                           | 22c. DATE SIGNED<br>6/28/79                                      |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lisa Chow MD.                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237                                                                                                    |                                                                               |                                                                           |                                                                  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       | 23b. DATE<br>JULY 2, 1979                                              |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY ROSARY CEM.                                                                                               |                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. BALTO. Md.           |                                                                  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM. A. FIALKOWSKI                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | ADDRESS<br>2007 EASTERN AVE                                                                                                                          |                                                                               | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                               |                                                                  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                  |  |

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COLLECTION

12





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 13790

|                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 |                                                        |                                                                                                                                                                 |  |                                                                                                 |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDWARD Harold PORTER</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>06 22 79</b> |                                                                                                                                                                 |  | 2b. HOUR<br><b>9:36P</b>                                                                        |  |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>White</b>                                                                                                                         |                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 11, 1909</b>                                                                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b>                                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                      |                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                                 |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N. CHARLES STREET</b> |                                                        |                                                                                                                                                                 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Sheet Metal Worker</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Martin Co.</b>                                                                     |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                 |                                                        | 13c. CITY OR TOWN<br><b>Middle River</b>                                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>12827 Eastern Ave. 21220</b>                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clinton Porter</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 |                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Louise Milburn</b>                                                                                     |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br><b>214 18 5473</b>                                                                                                  |                                                        | 17. INFORMANT<br>ADDRESS<br><b>12815 Eastern Alyce M. Wilkinson, Daughter Balto., Md. 20</b>                                                                    |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b><br><b>1509</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>SQUAMOUS CELL ESOPHAGEAL CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1 YEAR</b> |  |                                                                                                                                                 |                                                        |                                                                                                                                                                 |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 DAYS</b>                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>ANEMIA SECONDARY TO ESOPHAGEAL BLEEDING</b>                                                                                                                                                                                              |  |                                                                                                                                                 |                                                        |                                                                                                                                                                 |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                |                                                        |                                                                                                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                               |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                  |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                               |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>06/18</b> , 19 <b>79</b> , to <b>06/22</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>06/22</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.               |  |                                                                                                                                                 |                                                        |                                                                                                                                                                 |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                 |                                                        | DEGREE<br><b>MD.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>06/22/79</b>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. VIDAVER</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                 |                                                        | 22e. ADDRESS<br><b>GREATER BALTIMORE MEDICAL CENTER</b>                                                                                                         |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><b>6/25/79</b>                                                                                                                     |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ebenezer Meth Ch Cemetery</b>                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>                         |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 |                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                |  |                                                                                                                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 13791

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------|--------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------|------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | FIRST                                                                                                                                                    | MIDDLE | LAST                                                                           | 2a. DATE OF DEATH                                                   | MONTH                                          | DAY                                                            | YEAR | 2b. HOUR                                     |
| Irene J Preston                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                          |        |                                                                                | JUNE                                                                | 30                                             | 1979                                                           | 7-37 | M                                            |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                         |        | 6. AGE (IN YEARS LAST BIRTHDAY)                                                | IF UNDER 1 YEAR                                                     |                                                | IF UNDER 24 HRS                                                |      |                                              |
| Female                                                                                                                                                                                                                                                                                                                                                                                                            | White                                                                                                     | Nov. 15, 1890                                                                                                                                            |        | 88 YRS.                                                                        | MONTHS DAYS                                                         |                                                | HOURS MIN                                                      |      |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                                                     |                                                |                                                                |      |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                          | U.S.A.                                                                                                    |                                                                                                                                                          |        | Baltimore County, MD.                                                          |                                                                     |                                                |                                                                |      |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY              |                                                                |      |                                              |
| Rossville                                                                                                                                                                                                                                                                                                                                                                                                         | Franklin Square Hospital                                                                                  |                                                                                                                                                          |        | Housewife                                                                      |                                                                     |                                                |                                                                |      |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | 13b. COUNTY                                                                                                                                              |        | 13c. CITY OR TOWN                                                              |                                                                     | 13d. STREET ADDRESS                            |                                                                |      |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | Baltimore                                                                                                                                                |        | Baltimore                                                                      |                                                                     | Balt., Md. 21218<br>2810 Kennedy Avenue        |                                                                |      |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |        |                                                                                |                                                                     |                                                |                                                                |      |                                              |
| Henry                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | Emmart                                                                                                                                                   |        | Emma E. Jenkins                                                                |                                                                     |                                                |                                                                |      |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                                                                                                  |        | 17. INFORMANT                                                                  |                                                                     | ADDRESS                                        |                                                                |      |                                              |
| No                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | 213-48-6958                                                                                                                                              |        | Son:<br>Emmart H. Preston                                                      |                                                                     | Reisterstown, Md.<br>11604 Terrytown Dr. 21136 |                                                                |      |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest, Shock Lung</u><br>1541<br>DUE TO, OR AS A CONSEQUENCE OF <u>Syndrome</u><br>(b) <u>Carcinoma of Rectum</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                           |                                                                                                                                                          |        |                                                                                |                                                                     |                                                |                                                                |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                          |        |                                                                                |                                                                     |                                                |                                                                |      |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |        |                                                                                | 20a. AUTOPSY?                                                       |                                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |      |                                              |
| 6/27/79                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | Carcinoma of Rectum                                                                                                                                      |        |                                                                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                | YES <input type="checkbox"/> NO <input type="checkbox"/>       |      |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                             |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                               |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                     |                                                |                                                                |      |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                       |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                     |                                                |                                                                |      |                                              |
| 22a. I certify that (I/we) attended the deceased from June 19, 1979, to June 30, 1979, that (we) lost saw the deceased alive on June 30, 1979, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.                                                                                                                       |                                                                                                           | 22b. SIGNATURE<br>Harupudi                                                                                                                               |        |                                                                                | DEGREE<br>M.D.                                                      |                                                | 22c. DATE SIGNED<br>6/30/1979                                  |      |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | 22e. ADDRESS                                                                                                                                             |        |                                                                                |                                                                     |                                                |                                                                |      |                                              |
| S. R. - MARUPUDI M.D.                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | 9000 Franklin Square Drive 21237                                                                                                                         |        |                                                                                |                                                                     |                                                |                                                                |      |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | 23b. DATE                                                                                                                                                |        | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE     |                                                                |      |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | July 2 1979                                                                                                                                              |        | Cokesbury Cemetery                                                             |                                                                     | Abington Maryland                              |                                                                |      |                                              |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                          |        | 25a. DATE REC'D. BY REGISTRAR                                                  |                                                                     | 25b. REGISTRAR'S SIGNATURE                     |                                                                |      |                                              |
| Leonard J. Ruck, Inc. Baltimore, Maryland                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                          |        | JUL 2 1979                                                                     |                                                                     | R. J. Ruck                                     |                                                                |      |                                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 3 7 9 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                       |                                                                                                                                                             |                                                                              |                                                                                                   |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Thomas Melton Price                                                                                                                                                                                                                                                                                                       |                                                                                                                                       |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6-23-1979                             |                                                                                                   | 2b. HOUR<br>3:06 P.M.                                                                                                      |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br>White                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 24, 1920                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58<br>YRS.                                | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                                                                                                                                                                                                                                                                                                            | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                 |                                                                                                   |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic | 12b. KIND OF BUSINESS OR INDUSTRY<br>Auto                                                         |                                                                                                                            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                           |                                                                                                                                       |                                                                                                                                                             | 13b. CITY OR TOWN<br>Baltimore                                               |                                                                                                   | 13c. STREET ADDRESS<br>2829 Eastern Blvd. 21220                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard - Price                                                                                                                                                                                                                                                                                                        |                                                                                                                                       |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Kinzer                 |                                                                                                   |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                      |                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII 213 14 8682                                                                                 | 17. INFORMANT<br>ADDRESS<br>Alta Grace Price, wife Same                      |                                                                                                   |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>496- DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>C.O.P.D. + segmental lung resection</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>infection</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                                                       |                                                                                                                                                             |                                                                              |                                                                                                   |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                              |                                                                                                                                       |                                                                                                                                                             |                                                                              |                                                                                                   |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                         |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                    |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                     |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, ETC.)<br>N/A                                                                                     |                                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>805 FUSELAGE AVE. Baltimore County, Maryland |                                                                                                                            |
| 22a. I certify that (I) [this hospital] attended the deceased from June 19 58 to June 19 79, that (I) [we] last saw the deceased alive on June 19 19 and that in (my) [last] opinion death occurred on the date and hour and from the causes stated above. (I) [would] [did not] view the body after death.                                                      |                                                                                                                                       |                                                                                                                                                             |                                                                              |                                                                                                   |                                                                                                                            |
| 22b. SIGNATURE<br>[Signature]                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                       | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                              | 22c. DATE SIGNED<br>6/25/79                                                                       |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NARVIN J. Roubr MD.                                                                                                                                                                                                                                                                                                     |                                                                                                                                       | 22e. ADDRESS<br>805 FUSELAGE AVE.                                                                                                                           |                                                                              |                                                                                                   |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                           |                                                                                                                                       | 23b. DATE<br>6-26-79                                                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Cemetery                    |                                                                                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County, Maryland                                                   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Brudzinski Funeral Home PA 1407 Old Eastern Ave.                                                                                                                                                                                                                                                                         |                                                                                                                                       | 25a. DATE REC'D. BY REGISTRAR<br>JUN 25 1979                                                                                                                |                                                                              |                                                                                                   |                                                                                                                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2 4 1 2 4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Items #3215 Film G532 6/15/79 re<br>STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                               |  |                                                                                                                                           |                                                                     |                                                                                                                                                            |                                                                                                                                           |                                                                                      |                                                             |                                                                                                                            |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           |                                                                     |                                                                                                                                                            | REG. NO. 9 13793                                                                                                                          |                                                                                      |                                                             |                                                                                                                            |                                                                                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>John C. PULS</b>                                                                                                                                                                                                                                           |  |                                                                                                                                           |                                                                     |                                                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 7, 1979</b>                                                                                   |                                                                                      |                                                             | 2b. HOUR a<br><b>1:03 M</b>                                                                                                |                                                                                                 |  |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                   |  | 4 RACE<br><b>CAUCASIAN</b>                                                                                                                |                                                                     | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>01 01 02</b>                                                                                                          |                                                                                                                                           | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                     |                                                             | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                |                                                                     | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                           | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                   |                                                             |                                                                                                                            |                                                                                                 |  |
| 10 CITY OR TOWN OF DEATH<br><b>ROSSVILLE</b>                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |                                                                     |                                                                                                                                                            |                                                                                                                                           | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>     |                                                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>                                                                            |                                                                                                 |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           |                                                                     |                                                                                                                                                            | 13b. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                     |                                                                                      | 13c. CITY OR TOWN<br><b>ROSEDALE</b>                        |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN PULS</b>                                                                                                                                                                                                                                                                 |  |                                                                                                                                           |                                                                     |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LOUISA Stemm</b>                                                                          |                                                                                      |                                                             |                                                                                                                            |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                         |  |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br><b>215031110</b>                        |                                                                                                                                                            | 17 INFORMANT ADDRESS<br><b>MARY PULS 6498 GOLDEN RING RD.</b>                                                                             |                                                                                      |                                                             |                                                                                                                            |                                                                                                 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Most Probably Secondary to Myocardial Infarction</b> |  |                                                                                                                                           |                                                                     |                                                                                                                                                            |                                                                                                                                           |                                                                                      |                                                             |                                                                                                                            |                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                     |  |                                                                                                                                           |                                                                     |                                                                                                                                                            |                                                                                                                                           |                                                                                      |                                                             |                                                                                                                            |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                            |                                                                                                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                               |  |                                                                                                                                           | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |                                                                                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                            |                                                                                      |                                                             |                                                                                                                            |                                                                                                 |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                        |  |                                                                                                                                           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                            |                                                                                      |                                                             |                                                                                                                            |                                                                                                 |  |
| 22a. I certify that (this hospital) attended the deceased from <b>June 6, 1979</b> , to <b>June 7, 1979</b> , that (we) last saw the deceased alive on <b>June 7, 1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) did view the body after death.       |  |                                                                                                                                           |                                                                     |                                                                                                                                                            |                                                                                                                                           |                                                                                      |                                                             |                                                                                                                            |                                                                                                 |  |
| 22b. SIGNATURE<br><b>R. Darwish</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |                                                                     |                                                                                                                                                            | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                      |                                                             | 22c. DATE SIGNED<br><b>6-7-79</b>                                                                                          |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Riad Darwish</b>                                                                                                                                                                                                                                                           |  |                                                                                                                                           |                                                                     |                                                                                                                                                            | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>                                                                                   |                                                                                      |                                                             |                                                                                                                            |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                             |  |                                                                                                                                           | 23b. DATE<br><b>6/9/79</b>                                          |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER</b>                                                                                |                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO MD.</b> |                                                                                                                            |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Loeck</b>                                                                                                                                                                                                                                                                           |  |                                                                                                                                           |                                                                     |                                                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>                                                                                       |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Walter H. H. H.</b>        |                                                                                                                            |                                                                                                 |  |

2 1 6 1 4 1

DATE: 01/11/03



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 13794

|                                                                                                                          |                                                                                                                                      |                                                                                                                                                             |                                                                                      |                                                                        |                                                       |
|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Joy R Radecke</b>                                         |                                                                                                                                      |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 6 79</b>                                 |                                                                        | 2b. HOUR<br><b>14</b> M                               |
| 3 SEX<br><b>Female</b>                                                                                                   | 4 RACE<br><b>White</b>                                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 15 1944</b>                                                                                                      |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>35</b> YRS.                      |                                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Texas</b>                                                                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.    |                                                       |
| 10. CITY OR TOWN OF DEATH<br><b>Overlea</b>                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7617 Belair Road</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov.</b> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |                                                                                                                                      |                                                                                                                                                             | 13b. COUNTY<br><b>Baltimore</b>                                                      | 13c. CITY OR TOWN<br><b>Overlea</b>                                    |                                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elmer Gerloff</b>                                                           |                                                                                                                                      |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Beatrice Porter</b>              |                                                                        |                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                        |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>465-68-4584</b>                                                                                                              |                                                                                      | 17. INFORMANT<br>ADDRESS<br><b>Wm. Simmons 7900A. Rolling View Ave</b> |                                                       |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Ganglioglioma of brain*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*4 yrs.*Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                                                                                                                                                                    |                                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION<br><b>7/5-11/58</b>                                                                                                                                                                                                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Same</b>        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                               | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                     |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                  |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/19</b> 19 <b>79</b> <b>7/5</b> , to <b>6/6</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/19</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                        |                                                                                                                                                                    |                                                                                                                               |
| 22b. SIGNATURE<br><i>J.H. Weiner</i>                                                                                                                                                                                                                                                                                                                                         |                                                                        | DEGREE<br><b>MD.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>6/7/79</b>                                                                                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J.H. WEINER</b>                                                                                                                                                                                                                                                                                                                  |                                                                        | 22e. ADDRESS<br><b>1205 York Rd - 21093</b>                                                                                                                        |                                                                                                                               |

|                                                               |                            |                                                                  |                                                                              |
|---------------------------------------------------------------|----------------------------|------------------------------------------------------------------|------------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>6/9/79</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Middle River, Balt. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>   |                            | ADDRESS<br><b>7401 Belair Road</b>                               |                                                                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 2 1 1 1



Source

Version

Original

Notes

File

Path

Size

Date

Time

User

Group

Permissions

Attributes

Comments

Actions

Metadata



BOX-CO-1001 F185

FILE NAME

1001-185

Box-CO-1001 F185

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 13795

|                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  |                                                                                                                                                             |               |                                                                                                                                                                                                                                                                                                                                                           |                   |                                                                                                                            |            |                                           |            |                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------|------------|-------------------------------------------|------------|---------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                        |  | FIRST<br>LENA                                                                                                                        |  | MIDDLE                                                                                                                                                      | LAST<br>RADIN |                                                                                                                                                                                                                                                                                                                                                           | 2a. DATE OF DEATH |                                                                                                                            | MONTH<br>6 | DAY<br>8                                  | YEAR<br>79 | 2b. HOUR<br>1:45 P                                            |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>WHITE                                                                                                                     |  | 5. DATE OF BIRTH                                                                                                                                            |               | MONTH<br>UNKNOWN                                                                                                                                                                                                                                                                                                                                          |                   | YEAR                                                                                                                       |            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS |            | 7. IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN.         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                                                                                                                                                                                                                                                                              |                   |                                                                                                                            |            |                                           |            |                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>PIKESVILLE                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PIKESVILLE NURSING HOME |  |                                                                                                                                                             |               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DRESS MAKER                                                                                                                                                                                                                                                                           |                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>LADIES SHOP                                                                           |            |                                           |            |                                                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>NEW YORK                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY<br>NEW YORK                                                                                                              |  | 13c. CITY OR TOWN<br>BROOKLYN                                                                                                                               |               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                      |                   | 13e. STREET ADDRESS<br>3110 BRIGHTON 7TH ST.                                                                               |            |                                           |            |                                                               |  |
| 14. FATHER'S NAME<br>HARRY                                                                                                                                                                                                                                                                                                                                                                                 |  | MIDDLE                                                                                                                               |  | LAST<br>RADIN                                                                                                                                               |               | 15. MOTHER'S MAIDEN NAME<br>ESTHER                                                                                                                                                                                                                                                                                                                        |                   | MIDDLE<br>RACHEL                                                                                                           |            | LAST<br>UNKNOWN                           |            |                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>099-07-0615                                                               |  | 17. INFORMANT<br>ALLAN FREEDMAN                                                                                                                             |               | ADDRESS<br>6017 HIGHGATE DR. #21215                                                                                                                                                                                                                                                                                                                       |                   |                                                                                                                            |            |                                           |            |                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                      |  |                                                                                                                                                             |               |                                                                                                                                                                                                                                                                                                                                                           |                   |                                                                                                                            |            |                                           |            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr + 10 yrs |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>none</u>                                                                                                                                                                                                                                                        |  |                                                                                                                                      |  |                                                                                                                                                             |               |                                                                                                                                                                                                                                                                                                                                                           |                   |                                                                                                                            |            |                                           |            |                                                               |  |
| 19a. DATE OF OPERATION<br><u>none</u>                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  |                                                                                                                                                             |               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |            |                                           |            |                                                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>none</u> 19 <u>79</u>                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |               |                                                                                                                                                                                                                                                                                                                                                           |                   |                                                                                                                            |            |                                           |            |                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <u>none</u>                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE                                                                                                  |               | 21g. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> 19 <u>79</u> , to <u>6/8</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/8</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                   |                                                                                                                            |            |                                           |            |                                                               |  |
| 22a. SIGNATURE<br><u>Dr Maurice Feldman</u>                                                                                                                                                                                                                                                                                                                                                                |  | DEGREE<br><u>MD</u>                                                                                                                  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |               | 22c. DATE SIGNED<br><u>6/8/79</u>                                                                                                                                                                                                                                                                                                                         |                   |                                                                                                                            |            |                                           |            |                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DR MAURICE FELDMAN DR.</u>                                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS<br><u>6610 CROSS-COUNTRY BLVD.</u>                                                                                      |  |                                                                                                                                                             |               |                                                                                                                                                                                                                                                                                                                                                           |                   |                                                                                                                            |            |                                           |            |                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br>6-10-79                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW CONG.                                                                                                |               | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br>REISTERSTOWN BALTO. MD                                                                                                                                                                                                                                                                                |                   |                                                                                                                            |            |                                           |            |                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS. INC.<br>6010 REISTERSTOWN RD., BALTO., MD 21215                                                                                                                                                                                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 13 1979                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia Meluskey</u>                                                                                                      |               |                                                                                                                                                                                                                                                                                                                                                           |                   |                                                                                                                            |            |                                           |            |                                                               |  |

CP 101 81

(M)



W210

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                           |  |                                                                                                                                    |  |                                                                                              |  |                                                                                                                                                          |  |                                                                 |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                   |  | 13796 |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|-------------------|--|-------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLARENCE VERNON RAINEY</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                           |  |                                                                                                                                    |  | 2a. DATE KNOWN OF DEATH MATED <b>6 11 79</b>                                                 |  |                                                                                                                                                          |  | 2b. HOUR <b>M</b>                                               |  |                                                                                                         |  |                   |  |       |  |  |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE <b>White</b>      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6/13/1935</b>                                                                                |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>44</b> YRS.                                            |  | IF UNDER 1 YR. MONTHS DAYS                                                                                                                               |  | IF UNDER 24 HRS. HOURS MIN.                                     |  | 2c. DATE PRONOUNCED DEAD <b>6 13 79</b>                                                                 |  | 2d. HOUR <b>M</b> |  |       |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                           |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                         |  |                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD                                         |  |                   |  |       |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Dundalk</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                           |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2605 Yorkway Apt. D</b> |  |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>                                                                           |  |                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mfrgr.</b>                                                   |  |                   |  |       |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                        |  |                           |  |                                                                                                                                    |  |                                                                                              |  |                                                                                                                                                          |  |                                                                 |  |                                                                                                         |  |                   |  |       |  |  |  |
| 13a. STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY <b>Balto.</b> |  | 13c. CITY OR TOWN <b>Dundalk</b>                                                                                                   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>2605 Yorkway</b>                                                                                                                  |  | 13f. <b>21222</b>                                               |  |                                                                                                         |  |                   |  |       |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Ivan B. Rainey</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                           |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Susan Victoria Norton</b>                   |  |                                                                                                                                                          |  |                                                                 |  |                                                                                                         |  |                   |  |       |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                           |  | 16b. SOCIAL SECURITY NO. <b>1955-57</b>                                                                                            |  | 17. INFORMANT <b>Dundalk, Md. 21222</b>                                                      |  | 17a. <b>Ivan B. Rainey</b>                                                                                                                               |  | 17b. <b>22Centre Ave.</b>                                       |  |                                                                                                         |  |                   |  |       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4148</b> IMMEDIATE CAUSE (a) <b>Chronic ischemic myocardial disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                             |  |                           |  |                                                                                                                                    |  |                                                                                              |  |                                                                                                                                                          |  |                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                            |  |                   |  |       |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Chronic obstructive pulmonary disease, chronic alcoholism</b>                                                                                                                                                                                                                                                           |  |                           |  |                                                                                                                                    |  |                                                                                              |  |                                                                                                                                                          |  |                                                                 |  |                                                                                                         |  |                   |  |       |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                  |  |                                                                                              |  |                                                                                                                                                          |  |                                                                 |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |                   |  |       |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                               |  |                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                                                     |  |                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                 |  |                                                                                                         |  |                   |  |       |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                          |  |                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                        |  |                                                                                              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |  |                                                                 |  |                                                                                                         |  |                   |  |       |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                           |  |                                                                                                                                    |  |                                                                                              |  |                                                                                                                                                          |  |                                                                 |  |                                                                                                         |  |                   |  |       |  |  |  |
| ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                           |  | TITLE (SPECIFY) <b>Deputy</b>                                                                                                      |  |                                                                                              |  | MEDICAL EXAMINER                                                                                                                                         |  |                                                                 |  | DATE SIGNED <b>6/13/79</b>                                                                              |  |                   |  |       |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                           |  | ADDRESS <b>2112 DUNDALK AVE. BALTO. MD.</b>                                                                                        |  |                                                                                              |  |                                                                                                                                                          |  |                                                                 |  |                                                                                                         |  |                   |  |       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                           |  | 23b. DATE <b>6/14/1979</b>                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>                                        |  |                                                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b> |  |                                                                                                         |  |                   |  |       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Walter Brooks Bradley Inc Dundalk, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                           |  |                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1979</b>                                             |  |                                                                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE <b>Henry McBrady</b>                 |  |                                                                                                         |  |                   |  |       |  |  |  |

BP

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CAROLINE KERRY RAINY

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(M)

Chronic disease and related diseases

Chronic disease and related diseases

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X X

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20% SOLUTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. 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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                  |  |                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                |  | 7 9 1 3 7 9 7                                                                                                                 |  | REG. NO.                                                                                                                                                    |  |                                                                                                 |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>SHANKERLAL B RAWAL                                                                                                                                                                                                                                                                                                                |  |                                                                                                                               |  | 2a. DATE OF DEATH<br>6 24 79                                                                                                                                |  | 2b. HOUR<br>11:25 P M                                                                           |  |                                                                                                                            |  |
| 3 SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                         |  | 4 RACE<br>Indian                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 14 1900                                                                                                             |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.                                                       |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>India                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>India                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CO. MD.                                       |  |                                                                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Education                                                                             |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br>BALTO.                                                                                                         |  | 13c. CITY OR TOWN<br>COCKEYSVILLE                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>304 CRANBROOK RD 21030                                                                              |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bhulabhai Rawal                                                                                                                                                                                                                                                                                                              |  |                                                                                                                               |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Diwaliben Pandya                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>217-76-7693                                                                                       |  | 17. INFORMANT ADDRESS<br>M Dinker Rawal, 304 Cranbrook Rd.                                                                                                  |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary edema</u><br>4392<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD COPD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                   |  |                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                              |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                           |  |                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Kamal M. Jain</u>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                               |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |                                                                                                 |  | 22c. DATE SIGNED                                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KAMAL M. JAIN M.D.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                               |  | 22e. ADDRESS                                                                                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>6/29/79                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>J. E. Lowell Lemmon, 10 W. Padonia Rd.                                                                                                                                                                                                                                                                                        |  |                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 29 1979                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McBrady</u>                                              |  |                                                                                                                            |  |



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BALTIMORE CO.

ST. JOSEPH STREET

TOWSON

BY CRAWFORD TO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                        |  | REG. NO. 13798                                                                                                                                           |  |                                                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM GREGORY RAWLIN GS</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR HOUR <b>6/7/79-JUNE 7 1979 7:40 PM</b>                                                                                  |  |                                                                                                                         |  |
| 3. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE <b>Black</b>                                                                                                   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>6 29 1900</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>COUNTY</b> MD                                                                   |  |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>G.B.M.C.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret.</b>                                                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                 |  | 13c. CITY OR TOWN <b>Balto.</b>                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS <b>3601 Rosedale Rd.</b>                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>William G. Rawlings</b>                                                                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amanda R. Ford</b>                                                       |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO. <b>228-10-9161</b>                                                                            |  | 17. INFORMANT ADDRESS <b>Mrs. Dorothy Johnson Marley Pk.</b>                                                                                             |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4415</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>EXSANGUINATING HEMORRHAGE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>RUPTURED AORTIC ANEURYSM</b> |  |                                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                |  |                                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION <b>6/7/79</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>AORTIC ANEURYSM</b>                                                |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES; WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>6/5/79</b>                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/7/79</b> 19____, to <b>6/7/79</b> 19____, that (I) (we) lost saw the deceased alive on <b>6/7/79</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                      |  |                                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE <b>DR. F. BOOTH</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | DEGREE <b>MD</b>                                                                                                       |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |  | 22c. DATE SIGNED <b>6-8-79</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. F. BOOTH</b>                                                                                                                                                                                                                                                                                                                                                          |  | 22e. ADDRESS                                                                                                           |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE <b>6-11-79</b>                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>                                                                                                     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>                                                          |  |
| 24. FUNERAL DIRECTOR NAME <b>Samuel T. Redd</b>                                                                                                                                                                                                                                                                                                                                                                    |  | ADDRESS <b>5209 York Rd. Balto. Md.</b>                                                                                |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1979</b>                                                                                                         |  |                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                        |  | REGISTRAR'S SIGNATURE <b>Dorothy Johnson</b>                                                                                                             |  |                                                                                                                         |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                         |                                                                                                                                                                  |                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         | 7 9 1 3 7 9 9                                                                                                                                                    |                                                                                                                                                             |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Earl Robert Reaver</i>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         |                                                                                                                                                                  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>June 6 13 1979</i><br>2b. HOUR<br><i>10:00 AM</i>                                                                    |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE<br><i>White</i>                                                                                                                 | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>July 17 1912</i>                                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>66</i> YRS<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 74 HRS. HOURS MIN.                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD</i>                                                                                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                                                                                         |
| 10. CITY OR TOWN OF DEATH<br><i>Woodlawn</i>                                                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>2517 N. Rolling Rd.</i> |                                                                                                                                                                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Asst. Foreman</i><br>12b. KIND OF BUSINESS OR INDUSTRY<br><i>Gas &amp; Electric Co.</i> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>MD</i>                                                                                                                                                                                                                                                                                       |                                                                                                                                         | 13b. COUNTY<br><i>Baltimore</i>                                                                                                                                  | 13c. CITY OR TOWN<br><i>Woodlawn</i>                                                                                                                        |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Walter E. Reaver</i>                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Debbie Bostian</i>                                                                                              |                                                                                                                                                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>Yes</i>                                                                                                                                                                                                                                                                                                                          | 16b. SOCIAL SECURITY NO.<br><i>WW 11 216-12-2818</i>                                                                                    | 17. INFORMANT ADDRESS<br><i>Mr. Dennis Reaver</i><br><i>2517 N. Rolling Rd., Baltimore, MD 21207</i>                                                             |                                                                                                                                                             |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary occlusion</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Arteriosclerotic cardiovascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |                                                                                                                                         |                                                                                                                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Sudden</i><br><i>4 years</i>                                                                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                                                |                                                                                                                                         |                                                                                                                                                                  |                                                                                                                                                             |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                   |                                                                                                                                                             |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                |                                                                                                                                                             |
| 22a. I certify that (1) <del>XXXXXX</del> attended the deceased from <i>February</i> 19 <i>70</i> to <i>June</i> 19 <i>79</i> , that (1) <del>the</del> lost saw the deceased alive on <i>June 5</i> , 19 <i>79</i> , and that in (my <del>XXXX</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>XXXX</del> (did) <del>XXXX</del> view the body after death. |                                                                                                                                         |                                                                                                                                                                  |                                                                                                                                                             |
| 22b. SIGNATURE<br><i>Millard T. Traband</i>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                         | DEGREE<br><i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><i>6/15/79</i>                                                                                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Millard T. Traband</i>                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         | 22e. ADDRESS<br><i>1811 N. Rolling Rd., Baltimore, MD 21207</i>                                                                                                  |                                                                                                                                                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                               | 23b. DATE<br><i>6/16/79</i>                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lorraine Park Cem.</i>                                                                                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Woodlawn Baltimore MD</i>                                                                                     |
| 24. FUNERAL DIRECTOR <i>Loring Byers Funeral Directors, P.A.</i><br>NAME ADDRESS<br><i>8728 Liberty Rd., Randallstown, MD 21133</i>                                                                                                                                                                                                                                                                      |                                                                                                                                         | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 20 1979</i>                                                                                                              | 25b. REGISTRAR'S SIGNATURE<br><i>Loring Byers</i>                                                                                                           |

P P I E I P I



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VRA 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                |  | 7 9 1 3 8 0 0<br>REG. NO.                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                      |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                                         |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                        |  |
| MEYER                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  | RECHTMAN                                                                                     |  | 6-15-79                                                                                                                 |  |
| 3. SEX                                                                                                                                                                                                                                                                                                |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                              |  | 7b. HOUR                                                                                                                |  |
| MALE                                                                                                                                                                                                                                                                                                  |  | WHITE                                                                                                  |  | FEB. 25, 1888                                                                                                                                            |  | 91 YRS.                                                                                      |  | 9:40 P.M.                                                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                         |  |                                                                                                                         |  |
| POLAND                                                                                                                                                                                                                                                                                                |  | USA                                                                                                    |  |                                                                                                                                                          |  | BALTIMORE COUNTY MD.                                                                         |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| RANDALLSTOWN                                                                                                                                                                                                                                                                                          |  | BALTIMORE CO. GEN. HOSPITAL                                                                            |  |                                                                                                                                                          |  | MANUFACTURER                                                                                 |  | MEN'S CLOTHES                                                                                                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
| 13a. STATE                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS                                                                                                     |  |
| MARYLAND                                                                                                                                                                                                                                                                                              |  | BALTO.                                                                                                 |  | BALTIMORE                                                                                                                                                |  |                                                                                              |  | APT. 603<br>6800 LIBERTY RD. #21207                                                                                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                               |  |                                                                                              |  |                                                                                                                         |  |
| ABRAHAM                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | RECHTMAN                                                                                                                                                 |  |                                                                                              |  | SARAH BELLE                                                                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                                                   |  | 17. INFORMANT ADDRESS                                                                                                                                    |  |                                                                                              |  |                                                                                                                         |  |
| NO                                                                                                                                                                                                                                                                                                    |  | 218-32-3898                                                                                            |  | MRS. LEON KLEIN                                                                                                                                          |  | 6800 LIBERTY RD., APT. 608 #21207                                                            |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
| IMMEDIATE CAUSE (a) 1539 TERMINAL CA OF THE COLON                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
| RENAL FAILURE; ACUTE RESPIRATORY DISTRESS SYNDROME                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                              |  |                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                       |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                              |  |                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-15-79 to 6-15-79, that (I) (we) lost saw the deceased alive on 6-15-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                        |  | DEGREE                                                                                                 |  |                                                                                                                                                          |  | 22c. DATE SIGNED                                                                             |  |                                                                                                                         |  |
| ORLANO B. CONANAN, M.D.                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  | 6-15-79                                                                                      |  |                                                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                 |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                       |  | BOGA - RANDALLSTOWN MD 21133                                                                           |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                             |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                      |  |                                                                                                                         |  |
| BURIAL                                                                                                                                                                                                                                                                                                |  | JUNE 18, 1979                                                                                          |  | BALTIMORE HEBREW                                                                                                                                         |  | REISTERSTOWN BALTO. MD                                                                       |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR                                                                |  | 25b. REGISTRAR'S SIGNATURE                                                                                              |  |
|                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  | JUN 19 1979                                                                                  |  | [Signature]                                                                                                             |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                |  |                                                                                                                               |                                                                     |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                               | 7 9 13801                                                           |                                                                                                                                                             |                                                                                |                                                                                                                                            | REG. NO.                                                                                        |                                                                                                                            |                                                        |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>MARGARET M. REID                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                               | 2a. DATE OF DEATH<br>6 25 79                                        |                                                                                                                                                             |                                                                                | 2b. HOUR<br>12:30 A                                                                                                                        |                                                                                                 |                                                                                                                            |                                                        |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br>WHITE                                                                                                              |                                                                     | 5. DATE OF BIRTH<br>MAY 8, 1909                                                                                                                             |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS                                                                                                  |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                        |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, COUNTY MD.                                                                              |                                                                                                 |                                                                                                                            |                                                        |  |
| 10. CITY OR TOWN OF DEATH<br>Glen ARM                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>11932 GLEN ARM ROAD |                                                                     |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>AT HOME                                                                   |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                        |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                               | 13b. COUNTY<br>BALTO.                                               |                                                                                                                                                             | 13c. CITY OR TOWN<br>Glen ARM                                                  |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br>11932 GLEN ARM ROAD             |  |
| 14. FATHER'S NAME<br>John ADAM Link                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>MARY WERNEBURG                          |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                             |  |                                                                                                                               | 16b. SOCIAL SECURITY NO.<br>217-48-5928                             |                                                                                                                                                             | 17. INFORMANT ADDRESS<br>FAMILY RECORDS                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive cerebrovascular disease</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                               |                                                                     |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 yrs |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>Hypothyroidism compensated</u>                                                                                                                                                                                                           |  |                                                                                                                               |                                                                     |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                               |  |                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                           |  |                                                                                                                               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 48, to _____, 19 79, that (I) (we) lost<br>saw the deceased alive on _____, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                         |  |                                                                                                                               |                                                                     |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 22b. SIGNATURE<br>Frederick J. Vollmer MD.                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                               | DEGREE                                                              |                                                                                                                                                             |                                                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 |                                                                                                                            | 22c. DATE SIGNED<br>6-25-79                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FREDERICK J. VOLLMER MD.                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                               | 22e. ADDRESS<br>6100 YORK ROAD BALTO MD 21212                       |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                               | 23b. DATE<br>6-28-1979                                              |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>LAKE VIEW                                |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.                                        |                                                                                                                            |                                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>EVANS FUNERAL CHAPEL                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                               | ADDRESS<br>8800 HARFORD RD.                                         |                                                                                                                                                             |                                                                                | 25a. DATE RECEIVED BY REGISTRAR<br>JUL 2 1979                                                                                              |                                                                                                 | 25b. REGISTRAR'S SIGNATURE                                                                                                 |                                                        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |  |                                                                                                                                                                            |  |                                                                                |  |                                                                                      |                                                 | REG. NO. 9 13802                                                                                                           |                               |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |  |                                                                                                                                                                            |  | 2a. DATE OF DEATH                                                              |  |                                                                                      |                                                 |                                                                                                                            |                               |                                              |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Rosa P Reisinger                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |  |                                                                                                                                                                            |  | MONTH DAY YEAR<br>6 26 79                                                      |  |                                                                                      | 2b. HOUR<br>11:15P                              |                                                                                                                            |                               |                                              |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4 RACE<br>White                                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 13 1884                                                                                                                            |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>95 YRS.                                      |  |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS                  |                                                                                                                            | IF UNDER 24 HRS<br>HOURS MIN. |                                              |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                 |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                 |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                    |  |                                                                                      |                                                 |                                                                                                                            |                               |                                              |  |
| 10 CITY OR TOWN OF DEATH<br>Overlea                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4211 Fullerton Avenue |  |                                                                                                                                                                            |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaking |                                                                                                                            |                               |                                              |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |  |                                                                                                                                                                            |  | 13b. COUNTY<br>Baltimore                                                       |  | 13c. CITY OR TOWN<br>Overlea                                                         |                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                               | 13e. STREET ADDRESS<br>4211 Fullerton Avenue |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ambrose                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  |                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose                          |  |                                                                                      |                                                 |                                                                                                                            |                               |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>215-07-4778                                                                                                                                    |  | 17. INFORMANT<br>ADDRESS<br>Samuel Conti 3800 Taylor Avenue                    |  |                                                                                      |                                                 |                                                                                                                            |                               |                                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a) and (b).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Strokes - Adams - Cardiac Arrest</u><br>4148<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Myocardial Ischemia - Coronary artery Disease</u><br>(c) <u>Arteriosclerotic Cardiovascular Disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                    |  |                                                                                                                                                                            |  |                                                                                |  |                                                                                      |                                                 |                                                                                                                            |                               |                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    |  |                                                                                                                                                                            |  |                                                                                |  |                                                                                      |                                                 |                                                                                                                            |                               |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                           |  |                                                                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                               |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                      |                                                 |                                                                                                                            |                               |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                               |  |                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                      |                                                 |                                                                                                                            |                               |                                              |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>6/26</u> 19 <u>79</u> , to <u>6/26</u> 19 <u>79</u> , that (1) <del>was</del> lost saw the deceased alive on <u>Not seen</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (If true, did I draw the body after death.)                                                                               |  |                                                                                                                                    |  |                                                                                                                                                                            |  |                                                                                |  |                                                                                      |                                                 |                                                                                                                            |                               |                                              |  |
| 22b. SIGNATURE<br><u>Dr. Frank T. Kasik, Jr.</u>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |  | DEGREE (DR. John C. HYLE)<br>ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |                                                                                |  | 22c. DATE SIGNED<br>6/28/79                                                          |                                                 |                                                                                                                            |                               |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Frank T. Kasik, Jr.                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |  | 22e. ADDRESS<br>9005 Harford Road                                                                                                                                          |  |                                                                                |  |                                                                                      |                                                 |                                                                                                                            |                               |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>6/30/79                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer                                                                                                                   |  |                                                                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                          |                                                 |                                                                                                                            |                               |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lassahn Funeral Home                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |  | ADDRESS<br>7401 Belair Road                                                                                                                                                |  |                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                                          |                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>H. H. H. H.</u>                                                                           |                               |                                              |  |

MEDICAL CERTIFICATION

20821



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 13803

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                             |                                                                                                                                                             |                                                                             |                                                                                |                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARGARET A. REILLY                                                                                                                                                                                                                                                                                           |                                                                                                                             |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 13, 1979                        |                                                                                | 2b. HOUR<br>M                                                   |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br>WHITE                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOVEMBER 4, 1905                                                                                                      |                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>COUNTY MD.                             |                                                                 |
| 10. CITY OR TOWN OF DEATH<br>EASTPOINT                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7951 LANDSDALE |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                        |                                                                                                                             |                                                                                                                                                             | 13b. COUNTY<br>BALTIMORE                                                    |                                                                                | 13c. CITY OR TOWN<br>EASTPOINT                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARLEY ALEXANDER                                                                                                                                                                                                                                                                                                               |                                                                                                                             |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LINDA COMBS                |                                                                                |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO                                                                                                                                                                                                                                                                                                  |                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-14-4870                                                                                      |                                                                             | 17. INFORMANT<br>ADDRESS<br>HUSBAND - WILLIAM REILLY SAME AS ABOVE             |                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Probable ventricular fibrillation<br>4274<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                             |                                                                                                                                                             |                                                                             |                                                                                |                                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Long history alcohol abuse.                                                                                                                                                                                                       |                                                                                                                             |                                                                                                                                                             |                                                                             |                                                                                |                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                                                 |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                               |                                                                                                                             |                                                                                                                                                             |                                                                             |                                                                                |                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                             |                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                                                |                                                                                                                             |                                                                                                                                                             |                                                                             |                                                                                |                                                                 |
| 22b. SIGNATURE<br>J. Feldman                                                                                                                                                                                                                                                                                                                                             |                                                                                                                             | DEGREE<br>M.D.                                                                                                                                              |                                                                             | 22c. DATE SIGNED<br>6/14/79                                                    |                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>I. Feldman, M.D.                                                                                                                                                                                                                                                                                                                |                                                                                                                             | 22e. ADDRESS<br>Baltimore City Hosps.                                                                                                                       |                                                                             |                                                                                |                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                   |                                                                                                                             | 23b. DATE<br>JUNE 16, 1979                                                                                                                                  |                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH                         |                                                                 |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSSVILLE BALTIMORE MD.                                                                                                                                                                                                                                                                                                    |                                                                                                                             |                                                                                                                                                             |                                                                             |                                                                                |                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br>CONNELLY FUNERAL HOME 300 MACE                                                                                                                                                                                                                                                                                                           |                                                                                                                             | ADDRESS                                                                                                                                                     |                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 19 1979                                   |                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                             |                                                                                                                                                             |                                                                             | 25b. REGISTRAR'S SIGNATURE<br>Anthony MacReady                                 |                                                                 |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |                                                                     |                                                                                                                                                         |                                    |                                                                                                                                            |                                         |                                                                |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        | REG. NO. 79 13804                                                   |                                                                                                                                                         |                                    |                                                                                                                                            |                                         |                                                                |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        | FIRST MIDDLE LAST                                                   |                                                                                                                                                         |                                    | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                           |                                         |                                                                | 2b. HOUR                                     |
| Marcella A. Rever                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |                                                                     |                                                                                                                                                         |                                    | June 28 1979                                                                                                                               |                                         |                                                                | 2 M                                          |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                                   |  | 4 RACE                                                                                                 |                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                         |                                    | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                                                             |                                         | IF UNDER 1 YEAR MONTHS DAYS                                    |                                              |
| Female                                                                                                                                                                                                                                                                                                                                                                                  |  | White                                                                                                  |                                                                     | Aug 16 1884                                                                                                                                             |                                    | 94 YRS.                                                                                                                                    |                                         |                                                                |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |                                                                     | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                                                        |                                         |                                                                |                                              |
| Md                                                                                                                                                                                                                                                                                                                                                                                      |  | U. S. A.                                                                                               |                                                                     |                                                                                                                                                         |                                    | Baltimore Co MD.                                                                                                                           |                                         |                                                                |                                              |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                     |                                                                                                                                                         |                                    | 12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE)                                                                                 |                                         | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                              |
| Timonium                                                                                                                                                                                                                                                                                                                                                                                |  | College Manor                                                                                          |                                                                     |                                                                                                                                                         |                                    | House Painter                                                                                                                              |                                         | at Home                                                        |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE IN LAST ADMISSION)                                                                                                                                                                                                                                                                                                |  |                                                                                                        | 13a. CITY OR TOWN                                                   |                                                                                                                                                         |                                    | 13b. INSIDE CITY LIMITS?                                                                                                                   |                                         | 13c. STREET ADDRESS                                            |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        | 13b. COUNTY                                                         |                                                                                                                                                         |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |                                         | 4312 Arabia Ave                                                |                                              |
| Md                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        | Baltimore                                                           |                                                                                                                                                         |                                    |                                                                                                                                            |                                         |                                                                |                                              |
| 14 FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |                                                                                                                                                         |                                    |                                                                                                                                            |                                         |                                                                |                                              |
| Adolphus H. Weaver                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        | Emma Schipferling                                                   |                                                                                                                                                         |                                    |                                                                                                                                            |                                         |                                                                |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        | 16b. SOCIAL SECURITY NO                                             |                                                                                                                                                         |                                    | 17 INFORMANT ADDRESS                                                                                                                       |                                         |                                                                |                                              |
| No                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |                                                                     |                                                                                                                                                         |                                    | G. Hammond Rever 4312 Arabia Ave                                                                                                           |                                         |                                                                |                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardiovascular Disease</u>                                                                                                                                                                                                                  |  |                                                                                                        |                                                                     |                                                                                                                                                         |                                    |                                                                                                                                            |                                         |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |                                                                     |                                                                                                                                                         |                                    |                                                                                                                                            |                                         |                                                                |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |                                                                     |                                                                                                                                                         |                                    |                                                                                                                                            |                                         |                                                                |                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                                |  |                                                                                                        |                                                                     |                                                                                                                                                         |                                    |                                                                                                                                            |                                         |                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                         |                                    | 20a. AUTOPSY?                                                                                                                              |                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |                                                                     |                                                                                                                                                         |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                         | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                      |  |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |                                                                                                                                                         |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                         |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        | P.M. 19                                                             |                                                                                                                                                         |                                    |                                                                                                                                            |                                         |                                                                |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                         |  |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                         |                                    | 21f. LOCATION CITY OR TOWN COUNTY STATE                                                                                                    |                                         |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |                                                                     |                                                                                                                                                         |                                    |                                                                                                                                            |                                         |                                                                |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 9<sup>th</sup></u> 19 <u>79</u> , to <u>June 28<sup>th</sup></u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 25</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |                                                                                                        |                                                                     |                                                                                                                                                         |                                    |                                                                                                                                            |                                         |                                                                |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        | DEGREE                                                              |                                                                                                                                                         |                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                         | 22c. DATE SIGNED                                               |                                              |
| M. Kevin Quinn                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        | M.D.                                                                |                                                                                                                                                         |                                    |                                                                                                                                            |                                         | 6/28/79                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        | 22e. ADDRESS                                                        |                                                                                                                                                         |                                    |                                                                                                                                            |                                         |                                                                |                                              |
| M. KEVIN QUINN M.D.                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        | 1205 York Rd                                                        |                                                                                                                                                         |                                    | 21093.                                                                                                                                     |                                         |                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        | 23b. DATE                                                           |                                                                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY |                                                                                                                                            | 23d. LOCATION CITY OR TOWN COUNTY STATE |                                                                |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        | 6/30/79                                                             |                                                                                                                                                         | Loudon Park                        |                                                                                                                                            | Baltimore Co Md                         |                                                                |                                              |
| 24 FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                        | ADDRESS                                                             |                                                                                                                                                         |                                    | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |                                         | 25b. REGISTRAR'S SIGNATURE                                     |                                              |
| EVANS Funeral Chapel                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        | 8800 Harford Rd                                                     |                                                                                                                                                         |                                    | JUL 9 1979                                                                                                                                 |                                         | [Signature]                                                    |                                              |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 13805

|                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                            |  |                                                                                |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                 |  | 2a. DATE OF DEATH                                                                                                                          |  | 2b. HOUR                                                                       |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                       |  | 3. SEX                                                                                                                                     |  | 4. RACE                                                                        |                                              |
| VIRGINIA B. REYNOLDS                                                                                                                                                                                                                                                                                                   |  | Female                                                                                                                                     |  | Caucasian                                                                      |                                              |
| 5. DATE OF BIRTH                                                                                                                                                                                                                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                            |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                       |                                              |
| 9 - 07 - 97                                                                                                                                                                                                                                                                                                            |  | 81 YRS                                                                                                                                     |  | Massachusetts                                                                  |                                              |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |  | 10. CITY OR TOWN OF DEATH                                                      |                                              |
|                                                                                                                                                                                                                                                                                                                        |  | Baltimore County MD.                                                                                                                       |  | Towson                                                                         |                                              |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                                                                                                                                                                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                              |                                              |
| Greater Baltimore Medical Center                                                                                                                                                                                                                                                                                       |  | Homemaker                                                                                                                                  |  | Own Home                                                                       |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                             |  | 13b. CITY OR TOWN                                                                                                                          |  | 13c. STREET ADDRESS                                                            |                                              |
| Maryland                                                                                                                                                                                                                                                                                                               |  | Baltimore                                                                                                                                  |  | 305 Lochview Terrace                                                           |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME                                                                                                                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)              |                                              |
| Ezra                                                                                                                                                                                                                                                                                                                   |  | Lily                                                                                                                                       |  | NO                                                                             |                                              |
| 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                               |  | 17. INFORMANT                                                                                                                              |  | 17. ADDRESS                                                                    |                                              |
| 220-48-9513                                                                                                                                                                                                                                                                                                            |  | Dorothy R. Hottle, Same as #13e                                                                                                            |  |                                                                                |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                              |  |                                                                                                                                            |  |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                           |  |                                                                                                                                            |  |                                                                                |                                              |
| IMMEDIATE CAUSE (a) Upper Gastrointestinal Bleed, Massive                                                                                                                                                                                                                                                              |  |                                                                                                                                            |  |                                                                                | days                                         |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                |                                              |
| (b) Esophageal Varices                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                            |  |                                                                                | months                                       |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                |                                              |
| (c) Cirrhosis                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                | 2+ years                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                    |  |                                                                                                                                            |  |                                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  | 20a. AUTOPSY?                                                                  |                                              |
|                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                            |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                     |  | 21b. TIME OF INJURY                                                                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                              |
|                                                                                                                                                                                                                                                                                                                        |  | HOUR A.M. MONTH DAY YEAR                                                                                                                   |  |                                                                                |                                              |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION                                                                  |                                              |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                      |  |                                                                                                                                            |  | CITY OR TOWN COUNTY STATE                                                      |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from May 19 78, to June 13, 19 79, that (I) (we) last saw the deceased alive on June 12, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                            |  |                                                                                |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                         |  | DEGREE                                                                                                                                     |  | 22c. DATE SIGNED                                                               |                                              |
| Ronald L. Sirota                                                                                                                                                                                                                                                                                                       |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 6/13/79                                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS                                                                                                                               |  |                                                                                |                                              |
| Ronald L. Sirota, M.D.                                                                                                                                                                                                                                                                                                 |  | 6701 N. Charles St., Balto., Md. 21204                                                                                                     |  |                                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                              |  | 23b. DATE                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                              |
| Burial                                                                                                                                                                                                                                                                                                                 |  | 6-16-79                                                                                                                                    |  | Loudon Park Cemetery                                                           |                                              |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |  | 25b. REGISTRAR'S SIGNATURE                                                     |                                              |
| Ruck Towson Funeral Home, Inc. Towson, Md. 21204                                                                                                                                                                                                                                                                       |  | JUN 18 1979                                                                                                                                |  | [Signature]                                                                    |                                              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| FOR<br>1 - STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7 9 1 3 8 0 6                                                                                                                                |                                                                                           | REG. NO.                                                                                                                                                    |  |                                                                                                                                            |  |                                                                                                                            |  |                                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>AMANDA V RICHARDSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>16</b> YEAR <b>79</b>                          |                                                                                                                                                             |  | 2b. HOUR<br><b>12 noon</b>                                                                                                                 |  |                                                                                                                            |  |                                                   |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>White</b>                                                                                                                      |                                                                                           | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>07</b> YEAR <b>97</b>                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS                                                                                           |  | IF UNDER 1 YEAR<br>MONTHS <b>03</b> DAYS <b>21</b>                                                                         |  | IF UNDER 24 HRS<br>HOURS <b>12</b> MIN. <b>00</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   |                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b>                                                                               |  |                                                                                                                            |  |                                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Riverview Nursing Centre</b> |                                                                                           |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                       |  |                                                   |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br><b>Balto. Co.</b>                                                                                                             |                                                                                           | 13c. CITY OR TOWN<br><b>Balto. Co.</b>                                                                                                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |  | 13e. STREET ADDRESS<br><b>1130 West Cross St.<br/>Eastern Ave. 21221</b>                                                   |  | 21230                                             |
| 14. FATHER'S NAME<br>FIRST <b>James</b> MIDDLE <b>Frank</b> LAST <b>Frank</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mattie</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b> |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |                                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br><b>213-34-8308</b>                                                                                               |                                                                                           | 17. INFORMANT<br><b>Virginia Becker</b> ADDRESS <b>1605 Dagwood Lane, Belair, Md. 21014</b>                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gangrene, lower extremities.</b><br><b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Peripheral vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Diabetes Mellitus</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 months</b><br><b>8 years</b><br><b>11 years</b> |  |                                                                                                                                              |                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |                                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |                                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                             |                                                                                           |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                            |                                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                            |  |                                                                                                                            |  |                                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                       |                                                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                            |  |                                                                                                                            |  |                                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-5</b> , 19 <b>77</b> , to <b>6-13</b> , 19 <b>79</b> . that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                            |  |                                                                                                                                              |                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |                                                   |
| 22b. SIGNATURE<br><b>M. Rainess, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |                                                                                           | DEGREE                                                                                                                                                      |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6-16-79</b>                                                                                         |  |                                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MORRIS RAINESS, MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |                                                                                           | 22e. ADDRESS<br><b>1105 OLD EASTERN AVE. Balto. 21221</b>                                                                                                   |  |                                                                                                                                            |  |                                                                                                                            |  |                                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>June 20, 1979</b>                                                                                                            |                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk.</b>                                                                                            |  | 23d. LOCATION<br>CITY OR TOWN <b>Glen Burnie, Maryland</b> COUNTY STATE                                                                    |  |                                                                                                                            |  |                                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McGully Funeral Home of Brooklyn, Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |                                                                                           | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John A. Brady</b>                                                                                         |  |                                                                                                                            |  |                                                   |

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*Journal of Interpersonal Violence*

100% Satisfaction Guarantee

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                |  |                                                                                                                                                             |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>1- FOR STATE REGISTRAR</p> </div> <div> <p>7-9 13807</p> </div> </div>                                                                                                                                                                                                                |  |                                                                                                                                                |  |                                                                                                                                                             |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Frances Young RIENHOFF</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |  |                                                                                                                                                             | 2a. DATE OF DEATH<br><b>JUNE 29, 1979</b>                                               |                                                                                                 | 2b. HOUR<br><b>6:40 AM</b>    |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>White</b>                                                                                                                        |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>1902</b> YEAR                                                                                                     |                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                               |                               | IF UNDER 1 YEAR<br>MONTHS <b>77</b> DAYS <b>77</b> HOURS <b>77</b> MIN.                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |                               |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lutherville</b>                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>College Manor Nursing Home</b> |  |                                                                                                                                                             |                                                                                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                     |  |                                                                                                                                                |  |                                                                                                                                                             |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY                                                                                                                                    |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               | 13e. STREET ADDRESS<br><b>911 Poplar Hill Rd.</b>                                                                          |  |
| 14. FATHER'S NAME<br>FIRST <b>Hugh</b> MIDDLE <b>Hampton</b> LAST <b>Young</b>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Bessie</b> MIDDLE <b>Mason</b> LAST <b>Colston</b> |                                                                                                 |                               |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><b>213-34-2537</b>                                                                                                 |  | 17. INFORMANT<br><b>Hugh Young Rienhoff</b>                                                                                                                 |                                                                                         |                                                                                                 | ADDRESS<br><b>Balto., Md.</b> |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  |                                                                                                                                                             |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                |  |                                                                                                                                                             |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |
| IMMEDIATE CAUSE (a) <b>Heart failure</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                |  |                                                                                                                                                             |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>polyarteritis nodosa</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                |  |                                                                                                                                                             |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 years</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |  |                                                                                                                                                             |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                          |  |                                                                                                                                                |  |                                                                                                                                                             |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |  |                                                                                                                                                             |                                                                                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |
| 22a. I certify that (1) (the hospital) attended the deceased from <b>11/2</b> 19 <b>67</b> , to <b>6/29</b> 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>6/28</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |                                                                                                                                                |  |                                                                                                                                                             |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>William J. Fritz M.D.</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                |  | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                                                                         |                                                                                                 |                               | 22c. DATE SIGNED<br><b>6/29/79</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. William Fritz, M.D.</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                |  | 22e. ADDRESS<br><b>2 W. University Parkway Balto., Md.</b>                                                                                                  |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>6-30-79</b>                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>                                                                                                     |                                                                                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                 |                               |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 29 1979</b>                                                                                                         |                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>Henry W. Jenkins</b>                                           |                               |                                                                                                                            |  |
| 26. ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                |  |                                                                                                                                                             |                                                                                         |                                                                                                 |                               |                                                                                                                            |  |

10001 9A





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                 |                                                                                                 |                   |                                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|
| FOR<br>1. STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                 |                                                                                                 |                   |                                                                                                                                            |  |
| REG. NO. 79 13808                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                 |                                                                                                 |                   |                                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY E. LAST Ritenour                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 26 79                  |                                                                                                 | 2b. HOUR<br>450 M |                                                                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>White                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 25, 1908                                                                                                         |                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.                                                      |                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Va.                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |                   |                                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County Hospital |  |                                                                                                                                                             |                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seasonal emp.               |                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Fruit Proc.                                                                                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                 |                                                                                                 |                   |                                                                                                                                            |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br>Baltimore                                                                                                               |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   | 13e. STREET ADDRESS<br>7129 Windsor Mill Rd.                                                                                               |  |
| 14. FATHER'S NAME<br>FIRST Charles MIDDLE R. LAST Myers                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST Lillian MIDDLE Ann LAST Swope |                                                                                                 |                   |                                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>234-22-6888                                                                 |  | 17. INFORMANT<br>ADDRESS<br>21207<br>Mrs. Louise Hughes-Baltimore, Maryland                                                                                 |                                                                 |                                                                                                 |                   |                                                                                                                                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) cerebrovascular accident<br>436- DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) hypertension<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>56 hr<br>many years |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                 |                                                                                                 |                   |                                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                 |                                                                                                 |                   |                                                                                                                                            |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                 |                                                                                                 |                   |                                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |                                                                                                                                                             |                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                 |                                                                                                 |                   |                                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                 |                                                                                                 |                   |                                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 6-23-79 to 6-26-79, that (I) (we) last saw the deceased alive on 6-26-79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                                                                                                                      |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                 |                                                                                                 |                   |                                                                                                                                            |  |
| 22b. SIGNATURE<br>M. P. Ritenour                                                                                                                                                                                                                                                                                                                                                                                                   |  | DEGREE<br>MD                                                                                                                           |  | 22c. DATE SIGNED<br>6-26-79                                                                                                                                 |                                                                 |                                                                                                 |                   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. P. Ritenour                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |  | 22e. ADDRESS<br>Baltimore Gen'l Hosp                                                                                                                        |                                                                 |                                                                                                 |                   |                                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>June 28, 1979                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Reformed Cemetery                                                                                                     |                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Shepherdstown, Jefferson, W. Va.                  |                   |                                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME Charles W. Brown ADDRESS                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                                                                                                                 |                                                                 | 25b. REGISTRAR'S SIGNATURE<br>R. H. M. C. M.                                                    |                   |                                                                                                                                            |  |

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|              |                           |                                        |                   |
|--------------|---------------------------|----------------------------------------|-------------------|
| Female       | White                     | No. 12, 1908                           | 70                |
| M. A.        | C. A. A.                  | X                                      | Baltimore County, |
| Handallstown | Baltimore County Hospital | Seasonal and. M. A. H. P. Co.          |                   |
| Maryland     | Baltimore                 | 719 Windsor Hill Rd.                   |                   |
| Charles      | R. Myers                  | William                                | Ann               |
| No           | 134-11-8880               | Mrs. Louise Hughes-Baltimore, Maryland | 2000              |

x

Burial June 28, 1919 Reformed Cemetery, Shapardstown, Jefferson, A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13809

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EMMA CAROLYN ROBERTS</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 6, 1979</b>                |                                                                                                                                                             |  | 2b. HOUR<br><b>8:28am</b>                                                                                                                  |  |                                                                                                                            |                                                                 |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>White</b>                                                                                                                  |                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 19, 1902</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                                                                          |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>77</b>                                                                             |                                                                 |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                     |  | 7c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                                        |  |                                                                                                                            |                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Multi-Medical Center</b> |                                                                           |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tailor</b>                                                                         |                                                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                    |  |                                                                                                                                          | 13b. CITY OR TOWN<br><b>Harford</b>                                       |                                                                                                                                                             |  | 13c. INSIDE CITY LIMITS?<br><b>YES</b> NO <input type="checkbox"/>                                                                         |  |                                                                                                                            | 13d. STREET ADDRESS<br><b>4011 Federal Rd.</b>                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Phillip Diegert</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Elligson</b> |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                    |  |                                                                                                                                          | 16b. SOCIAL SECURITY NO.<br><b>216-10-6704D</b>                           |                                                                                                                                                             |  | 17. INFORMANT<br>ADDRESS<br><b>Elaine Martin, 4011 Federal Rd.</b>                                                                         |  |                                                                                                                            |                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Melanotic CA</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>CMT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                          |                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Prior Myocardial Infarct</b>                                                                                                                                                                                          |  |                                                                                                                                          |                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                         |  |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |                                                                                                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                            |                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                        |  |                                                                                                                                          | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |                                                                                                                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 16, 1979</b> , to <b>June 6, 1979</b> , that (I) (we) lost saw the deceased alive on <b>June 4, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                    |  |                                                                                                                                          |                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |                                                                 |  |
| 22b. SIGNATURE<br><b>Howard Bond</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                          | DEGREE<br><b>MD</b>                                                       |                                                                                                                                                             |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/6/79</b>                                                                                          |                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Howard Bond, M.D.</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                          | 22e. ADDRESS<br><b>9618 Belair Rd. 21236</b>                              |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          | 23b. DATE<br><b>June 9, 1979</b>                                          |                                                                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk.</b>                                                                          |  |                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |                                                                           |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |                                                                 |  |
| 6009 Harford Rd., Balto., Md. 21214                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |                                                                 |  |

BP

90031



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                      |  |                                                                                                                                                    |  |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                           |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                    |  | 7 9                                                                                                                                                |  | 1 3 8 1 0                                                                                                                                                  |  | REG. NO.                                                                                       |  |                                                                                                                           |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br><b>Owen R. Roe</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                    |  | 2a DATE OF DEATH<br>MONTH <b>6</b> DAY <b>27</b> YEAR <b>79</b>                                                                                            |  | 2b HOUR<br><b>4:30 PM</b>                                                                      |  |                                                                                                                           |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                      |  | 4 RACE<br><b>White</b>                                                                                                                             |  | 5 DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>27</b> YEAR <b>86</b>                                                                                             |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b>                                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                 |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                               |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                          |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                              |  |                                                                                                                           |  |
| 10 CITY OR TOWN OF DEATH<br><b>Essex, Md.</b>                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Riverview Nursing Centre, Inc.</b> |  |                                                                                                                                                            |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>            |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>                                                                   |  |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                              |  | 13b COUNTY<br><b>Baltimore</b>                                                                                                                     |  | 13c CITY OR TOWN<br><b>Essex</b>                                                                                                                           |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS<br><b>608 Franklin Avenue 21221</b>                                                                    |  |
| 14 FATHER'S NAME<br>FIRST <b>Joseph</b> MIDDLE <b>Roe</b> LAST <b>Roe</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                    |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>-</b> LAST <b>Baldwin</b>                                                                           |  |                                                                                                |  |                                                                                                                           |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>yes WWI</b>                                                                                                                                                                                                                                         |  | 16b SOCIAL SECURITY NO<br><b>WWI</b>                                                                                                               |  | 17 INFORMANT<br><b>213-07-1246</b>                                                                                                                         |  | ADDRESS<br><b>Mrs. Elba Roe 608 Franklin Ave. 21221</b>                                        |  |                                                                                                                           |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>486-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> |  |                                                                                                                                                    |  |                                                                                                                                                            |  |                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>                                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                          |  |                                                                                                                                                    |  |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                           |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                    |  |                                                                                                                                                            |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                          |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                |  |                                                                                                                           |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                              |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                |  |                                                                                                                           |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>26 June 19 79</b> to <b>27 June 19 79</b> , that (I) (we) lost<br>saw the deceased alive on <b>27 June 19 79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) not view the body after death.               |  |                                                                                                                                                    |  |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                           |  |
| 22b SIGNATURE<br><b>MORRIS KAINES, MD</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                    |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |                                                                                                |  | 22c DATE SIGNED<br><b>6/27/79</b>                                                                                         |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MORRIS KAINES, MD</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  | 22e ADDRESS<br><b>1105 Old Eastern Ave Balt. Md. 21221</b>                                                                                                 |  |                                                                                                |  |                                                                                                                           |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                 |  | 23b DATE<br><b>6-29-79</b>                                                                                                                         |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                                                                              |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Maryland</b>                 |  |                                                                                                                           |  |
| 24 FUNERAL DIRECTOR<br><b>Brudzinski Funeral Home PA 1407 Old Eastern Ave</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 29 1979</b>                                                                                                         |  | 25b REGISTRAR'S SIGNATURE<br><b>History McCreedy</b>                                           |  |                                                                                                                           |  |

BP

1 2 8 1 0

yes, all  
212-07-1346  
Mr. John Lee 902 Franklin Av. 21221  
-  
Baltimore, Md.  
Frank, Mr.  
New River Building Center, Inc.  
Baltimore County  
Construction

1-2-72  
1-2-72  
1-2-72

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 13811

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |                                                                                             |                                                                                                                                                             |                                                                 |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EMMA THERESA ROESINGER</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>28</b> YEAR <b>79</b>                            |                                                                                                                                                             |                                                                 | 2b. HOUR<br><b>2:25</b> AM                                                                                                                 |                                                                                                 |                                                                                                                            |                                              |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                      |                                                                                             | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>11</b> YEAR <b>1882</b>                                                                                          |                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS                                                                                           |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS <b>6</b> DAYS <b>6</b> HOURS <b>6</b> MIN                                                        |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                       |                                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE Co. MD.</b>                                                                           |                                                                                                 |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>STELLA MARIS</b> |                                                                                             |                                                                                                                                                             |                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>                                                         |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SALES</b>                                                                          |                                              |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  | 13b. COUNTY<br><b>BALT.</b>                                                                 |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>TOWSON</b>                              |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            |                                              |
| 13e. STREET ADDRESS<br><b>TOWSON, MD.</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                  |                                                                                             |                                                                                                                                                             |                                                                 |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                              |
| 14. FATHER'S NAME<br>FIRST <b>HENRY</b> MIDDLE <b>FILBERT</b> LAST <b>ANN</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANNA</b> MIDDLE <b>ROESINGER</b> LAST <b>ROESINGER</b> |                                                                                                                                                             |                                                                 |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br><b>212-01-3213A</b>                                             |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>STELLA MARIS TOWSON, MD.</b>     |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GASTRO INTEST. BLEEDING</b><br><b>4392</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                                  |                                                                                             |                                                                                                                                                             |                                                                 |                                                                                                                                            |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):                                                                                                                                                                                                                                                  |  |                                                                                                                                  |                                                                                             |                                                                                                                                                             |                                                                 |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                            |                                                                                                                                                             |                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                             |  |                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                           |                                                                                                                                                             |                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                 |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                         |  |                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                      |                                                                                                                                                             |                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                 |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-8</b> 19 <b>60</b> , to <b>6-28</b> 19 <b>79</b> , that (I) (we) lost<br>saw the deceased alive on <b>6-28</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                    |  |                                                                                                                                  |                                                                                             |                                                                                                                                                             |                                                                 |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><b>E.L. ROBBINS</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                  | DEGREE                                                                                      |                                                                                                                                                             |                                                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>6-28-79</b>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E.L. ROBBINS</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                  | 22e. ADDRESS<br><b>1205 YORK RD. LUTHERVILLE, MD.</b>                                       |                                                                                                                                                             |                                                                 |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                  | 23b. DATE<br><b>6/30/79</b>                                                                 |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b> |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>Maryland</b>     |                                                                                                                            |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                  | ADDRESS<br><b>7401 Belair Road</b>                                                          |                                                                                                                                                             |                                                                 | 25a. DATE RECEIVED BY REGISTRAR<br><b>JUL 2 1979</b>                                                                                       |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                           |                                              |



11811





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |                                                                         |                                                                                                                                                             |                                               |                                                                                      |                                                                                                 |                                                                                                                            |                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edward M. Rykowski Sr</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 29 1979</b>                 |                                                                                                                                                             |                                               | 2b. HOUR<br><b>1;30</b><br>A M                                                       |                                                                                                 |                                                                                                                            |                                                 |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 4 RACE<br><b>White</b>                                                                                                                |                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 24 1919</b>                                                                                                      |                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b><br>YRS.                                 |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                            |                                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b><br>MD.               |                                                                                                 |                                                                                                                            |                                                 |  |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>628 Fairway Drive</b> |                                                                         |                                                                                                                                                             |                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner</b>     |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hardware</b>                                                                       |                                                 |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       | 13b. COUNTY<br><b>Balto</b>                                             |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Knollwood</b>         |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>628 Fairway Drive</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph T Rykowski</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eleanor Unknown</b>                                                                                     |                                               |                                                                                      |                                                                                                 |                                                                                                                            |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>WWII</b> |                                                                                                                                                             | 17. INFORMANT<br><b>Catherine S. Rykowski</b> |                                                                                      | ADDRESS<br><b>Same</b>                                                                          |                                                                                                                            |                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE CARDIOMYOPATHY</b><br><b>4054</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>HYPERTENSIVE DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                       |                                                                         |                                                                                                                                                             |                                               |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 YRS</b><br><b>13 YRS</b>                                              |                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                             |  |                                                                                                                                       |                                                                         |                                                                                                                                                             |                                               |                                                                                      |                                                                                                 |                                                                                                                            |                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |                                                                         |                                                                                                                                                             |                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                     |                                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                               |                                                                                      |                                                                                                 |                                                                                                                            |                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |                                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                               |                                                                                      |                                                                                                 |                                                                                                                            |                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 19 66</b> , to <b>JUNE 19 79</b> , that (I) <del>was</del> last saw the deceased alive on <b>JUNE 18 19 79</b> , and that in (my) <del>four</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.                          |  |                                                                                                                                       |                                                                         |                                                                                                                                                             |                                               |                                                                                      |                                                                                                 |                                                                                                                            |                                                 |  |
| 22b. SIGNATURE<br><b>Clarence W. Ledoux</b> DEGREE <b>M.D.</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |                                                                         |                                                                                                                                                             |                                               | 22c. DATE SIGNED<br><b>6-29-79</b>                                                   |                                                                                                 |                                                                                                                            |                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Clarence W. Ledoux M.D.</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                       |                                                                         |                                                                                                                                                             |                                               | 22e. ADDRESS<br><b>3023 Eastern Ave</b>                                              |                                                                                                 |                                                                                                                            |                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>7/2/1979</b>                                                                                                          |                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Crematory</b>                                                                                           |                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                   |                                                                                                 |                                                                                                                            |                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Rd.</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |                                                                         |                                                                                                                                                             |                                               | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 5 1979</b>                                   |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                           |                                                 |  |

MEDICAL CERTIFICATION



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                          |                                                                                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Blanche L Saddler</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 12 1979</b>             |                                                                                                                                                             |                                                                                | 2b. HOUR<br><b>5:25 A.M.</b>                                                                                                               |                                                                          |                                                                                                                                       |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>White</b>                                                                                                                              |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 8 1891</b>                                                                                                    |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>                                                                                               |                                                                          | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                          |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                                        |                                                                          |                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                       |                                                                          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                                                                                         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                               |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                          |                                                                                                                                       |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><b>Balto</b>                                                                                                                          |                                                                        | 13c. CITY OR TOWN<br><b>Phoenix</b>                                                                                                                         |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            |                                                                          | 13e. STREET ADDRESS<br><b>3906 Sweet Air Rd, 21131</b>                                                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James W. Garner</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara Ways</b>             |                                                                                                                                            |                                                                          |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                      | 16b. SOCIAL SECURITY NO<br><b>--</b>                                   |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Marion Clarke, 3906 Sweet Air Rd.</b>      |                                                                                                                                            |                                                                          |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Pulmonary emboli</b><br><b>4151</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b>                                                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Pulmonary edema</b>                                                                                                                                                                                                         |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                          |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                       |                                                                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |  |                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                                            |                                                                          |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                             |  |                                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                            |                                                                          |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/1</b> 19 <b>79</b> to <b>6/12</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/12</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                          |                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>Ronald L. Sirota</b> DEGREE <b>MD</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                                | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                          | 22c. DATE SIGNED<br><b>6/12/79</b>                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ronald L. Sirota, M.D.</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>6701 N. Charles St, Towson, Md. 21204</b>                   |                                                                                                                                            |                                                                          |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                      | 23b. DATE<br><b>6/14/79</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>              |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |                                                                                                                                       |  |
| 24. FUNERAL HOME<br>NAME <b>J. E. Lowell Lemmon</b> ADDRESS <b>10 W. Padonia Rd.</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 13 1979</b>                                                                                        |                                                                          | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey McNeely</b>                                                                                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |                                                                                     |                                                                                                                                                             |                                                          |                                                                                      |                                                                                                 |                                                                                                                                          |                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM H. SALTER</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>02</b> YEAR <b>79</b>                    |                                                                                                                                                             |                                                          | 2b. HOUR<br><b>1:05 AM</b>                                                           |                                                                                                 |                                                                                                                                          |                                                 |  |
| 3 SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                  |  | 4 RACE<br><b>W</b>                                                                                                                        |                                                                                     | 5. DATE OF BIRTH<br>MONTH <b>04</b> DAY <b>04</b> YEAR <b>1886</b>                                                                                          |                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS.                                    |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.                                                                     |                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |                                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CO. MD.</b>                        |                                                                                                 |                                                                                                                                          |                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTO. CO. GEN. Hosp.</b> |                                                                                     |                                                                                                                                                             |                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PLUMBER</b>   |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>                                                                                      |                                                 |  |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                           | 13b. COUNTY<br><b>BALTO.</b>                                                        |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>BALTO.</b>                       |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                          | 13e. STREET ADDRESS<br><b>7801 LYONMILL RD.</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>Wm.</b> MIDDLE <b>H.</b> LAST <b>SALTER</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>UNKNOWN</b> MIDDLE <b>S</b> LAST <b>SALTER</b> |                                                                                                                                                             |                                                          |                                                                                      |                                                                                                 |                                                                                                                                          |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                  |  |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br><b>216-10-1549</b>                                      |                                                                                                                                                             | 17. INFORMANT<br><b>MARTHA K. SALTER</b>                 |                                                                                      | ADDRESS<br><b>SAME. 21107</b>                                                                   |                                                                                                                                          |                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Int. obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>cardio-resp. failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>4289</b>                                                       |  |                                                                                                                                           |                                                                                     |                                                                                                                                                             |                                                          |                                                                                      |                                                                                                 |                                                                                                                                          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                               |  |                                                                                                                                           |                                                                                     |                                                                                                                                                             |                                                          |                                                                                      |                                                                                                 |                                                                                                                                          |                                                 |  |
| 19a. DATE OF OPERATION<br><b>5-17-1979</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>cardio-resp. failure</b>     |                                                                                                                                                             |                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                           |  |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                   |                                                                                                                                                             |                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                 |                                                                                                                                          |                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                               |  |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |                                                                                                                                                             |                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                 |                                                                                                                                          |                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-17-1979</b> , to <b>6-2-1979</b> , that (I) (we) last saw the deceased alive on <b>6-2-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                           |                                                                                     |                                                                                                                                                             |                                                          |                                                                                      |                                                                                                 |                                                                                                                                          |                                                 |  |
| 22b. SIGNATURE<br><b>B. Narayana MD</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                           |                                                                                     |                                                                                                                                                             |                                                          | DEGREE<br><b>MD</b>                                                                  |                                                                                                 | 22c. DATE SIGNED<br><b>6-2-79</b>                                                                                                        |                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. NARAYANA</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                           |                                                                                     |                                                                                                                                                             |                                                          | 22e. ADDRESS                                                                         |                                                                                                 |                                                                                                                                          |                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                      |  |                                                                                                                                           | 23b. DATE<br><b>6-5-79</b>                                                          |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DRUID RIDGE</b> |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. CO. MD</b>                              |                                                                                                                                          |                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>NEWELL F.H</b> ADDRESS <b>PIKESVILLE MD.</b>                                                                                                                                                                                                                                                       |  |                                                                                                                                           |                                                                                     |                                                                                                                                                             |                                                          | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1979</b>                                   |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>                                                                                     |                                                 |  |



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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

13815

|                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                                                                |                                                                                                                                            |                                                                |                                   |          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | FIRST                                                                                                                                                       | MIDDLE                                                           | LAST                                                                           | 2a. DATE OF DEATH                                                              | MONTH                                                                                                                                      | DAY                                                            | YEAR                              | 2b. HOUR |
| REGINA                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |                                                                  | A. SAWYER                                                                      | JUNE 9, 1979                                                                   |                                                                                                                                            |                                                                |                                   | 8:15P    |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                                                        | 4 RACE                                                                                                    | 5. DATE OF BIRTH                                                                                                                                            |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                | IF UNDER 1 YEAR                                                                |                                                                                                                                            | IF UNDER 24 HRS                                                |                                   |          |
| Female                                                                                                                                                                                                                                                                                                                                                                                                       | White                                                                                                     | Oct. 22, 1908                                                                                                                                               |                                                                  | 70                                                                             | MONTHS                                                                         |                                                                                                                                            | DAYS                                                           |                                   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                                                                |                                                                                                                                            |                                                                |                                   |          |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                     | USA                                                                                                       |                                                                                                                                                             |                                                                  | BALTIMORE COUNTY MD.                                                           |                                                                                |                                                                                                                                            |                                                                |                                   |          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY                                              |                                                                                                                                            |                                                                |                                   |          |
| TOWSON                                                                                                                                                                                                                                                                                                                                                                                                       | St. Joseph's Hospital                                                                                     |                                                                                                                                                             | Homemaker                                                        |                                                                                | Own Home                                                                       |                                                                                                                                            |                                                                |                                   |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 13b. CITY OR TOWN                                                                                                                                           |                                                                  | 13c. INSIDE CITY LIMITS?                                                       |                                                                                | 13d. STREET ADDRESS                                                                                                                        |                                                                |                                   |          |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           | Baltimore                                                                                                                                                   |                                                                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                                                                | 4 E. 32nd St. Apt. 606                                                                                                                     |                                                                |                                   |          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |                                                                  |                                                                                |                                                                                |                                                                                                                                            |                                                                |                                   |          |
| Unknown                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | Unknown                                                                                                                                                     |                                                                  |                                                                                |                                                                                |                                                                                                                                            |                                                                |                                   |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | 16b. SOCIAL SECURITY NO                                                                                                                                     |                                                                  | 17. INFORMANT                                                                  |                                                                                | ADDRESS                                                                                                                                    |                                                                |                                   |          |
| No                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | 217-20-7815                                                                                                                                                 |                                                                  | Mr. Lewis Sawyer                                                               |                                                                                | Same                                                                                                                                       |                                                                |                                   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>486-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>BILATERAL PNEUMONIA</u><br>(c) <u>BILATERAL PNEUMONIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 DAYS</u><br><u>2 DAYS</u> |                                                                                                                                            |                                                                |                                   |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>CHRONIC OBSTRUCTIVE LUNG DISEASE; MALNUTRITION</u>                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                                                                |                                                                                                                                            |                                                                |                                   |          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                  |                                                                                | 20a. AUTOPSY?                                                                  |                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |          |
|                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                | YES <input type="checkbox"/> - NO <input checked="" type="checkbox"/>          |                                                                                                                                            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                     |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                |                                                                                                                                            |                                                                |                                   |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                    |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                |                                                                                                                                            |                                                                |                                   |          |
| 22a. I certify that (this hospital) attended the deceased from <u>6-7</u> 19 <u>79</u> to <u>6-9</u> 19 <u>79</u> , that (we) lost<br>saw the deceased alive on <u>6-9</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (we) (did) (not) view the body after death.                                                                |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                |                                                                                |                                                                                                                                            |                                                                |                                   |          |
| 22b. SIGNATURE<br><u>George C. Secada-Lovio, MD</u>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             |                                                                  | DEGREE                                                                         |                                                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                | 22c. DATE SIGNED<br><u>6-9-79</u> |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>GEORGE C. SECADA-LOVIO, MD</u>                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             |                                                                  | 22e. ADDRESS<br><u>ST. JOSEPH'S HOSPITAL BALT., MD</u>                         |                                                                                |                                                                                                                                            |                                                                |                                   |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 23b. DATE                                                                                                                                                   |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                                 |                                                                |                                   |          |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | 6-12-79                                                                                                                                                     |                                                                  | Moreland Memorial                                                              |                                                                                | Baltimore County, Md.                                                                                                                      |                                                                |                                   |          |
| 24. FUNERAL DIRECTOR<br>NAME <u>Henry W. Jenkins &amp; Sons Co.</u><br>ADDRESS <u>4905 York Road Balto., Md. 21212</u>                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |                                                                  | 25a. DATE REC'D. BY REGISTRAR                                                  |                                                                                | 25b. REGISTRAR'S SIGNATURE<br><u>Shirley M. Brady</u>                                                                                      |                                                                |                                   |          |
|                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |                                                                  | JUN 11 1979                                                                    |                                                                                |                                                                                                                                            |                                                                |                                   |          |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01001 01





1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 13816

|                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |                                                           |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Bertha Anna SCHAEFER</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                         | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 6, 1979</b> |                                                                                                                                                            |  | 2b HOUR<br><b>4 A M</b>                                                                        |  |                                                                                                                            |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                          |  | 4 RACE<br><b>White</b>                                                                                                                  |                                                           | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 5, 1892</b>                                                                                                  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>                                                    |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>                                                                             |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                 |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |                                                           | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                            |  |                                                                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br><b>Timonium</b>                                                                                                                                                                                                                                                                                                     |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>130 E. Timonium Road</b> |                                                           |                                                                                                                                                            |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                        |  |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                    |  | 13b COUNTY<br><b>Baltimore</b>                                                                                                          |                                                           | 13c CITY OR TOWN<br><b>Timonium</b>                                                                                                                        |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS<br><b>130 E. Timonium Road</b>                                                                          |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles O. Reckner</b>                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |                                                           | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Arminta Brenneman</b>                                                                                   |  |                                                                                                |  |                                                                                                                            |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>                                                                    |                                                           | 17 INFORMANT<br>ADDRESS<br><b>Grants St.<br/>Mary McKenzie, Grantsville, Md.</b>                                                                           |  |                                                                                                |  |                                                                                                                            |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>HEART FAILURE / INFECTION</b><br>(c) <b>ASCEND. AGE</b>      |  |                                                                                                                                         |                                                           |                                                                                                                                                            |  |                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b>                                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>BEDRIDDEN 2 ARTHRITIS - S/P HIP FX.</b>                                                                                                                                                                |  |                                                                                                                                         |                                                           |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                            |  |
| 19a DATE OF OPERATION<br><b>N/A</b>                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>---</b>                                                                          |                                                           |                                                                                                                                                            |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A</b>                                                                           |                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>---</b>                                                               |  |                                                                                                |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>---</b>                                                    |                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>---</b>                                                                                            |  |                                                                                                |  |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>19 74</b> to <b>JUNE 5</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>JUNE 5</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |                                                                                                                                         |                                                           |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Robert W. Lisle</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |                                                           | DEGREE<br><b>MD</b>                                                                                                                                        |  |                                                                                                |  | 22c. DATE SIGNED<br><b>June 6, 1979</b>                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT W. LISLE</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |                                                           | 22e. ADDRESS<br><b>57 W. TIMONIUM RD TIMONIUM MD 21093</b>                                                                                                 |  |                                                                                                |  |                                                                                                                            |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                    |  | 23b DATE<br><b>6-9-1979</b>                                                                                                             |                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grantsville Cem.</b>                                                                                              |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Grantsville, Garrett, Md.</b>                  |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>D. Lynn Newman</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |                                                           | ADDRESS<br><b>Grantsville, Md.</b>                                                                                                                         |  | 25a. DATE REC'D BY REGISTRAR<br><b>JUN 22 1979</b>                                             |  | 25b. REC'D BY<br><b>---</b>                                                                                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 3 8 1 6

|                          |                      |         |                             |        |
|--------------------------|----------------------|---------|-----------------------------|--------|
| June 6, 1979             | Bertha               | Anna    | White                       | Tennie |
| 86                       | 1979. 5, 1992        | USA     | Tennessee                   |        |
| Baltimore County,        | x                    |         |                             |        |
| 150 E. Timonium Road     | 150 E. Timonium Road |         | Timonium                    |        |
| 150 E. Timonium Road     | x                    |         | Maryland Baltimore Timonium |        |
| Granville, MA            | Granville            | Beckner | Charles                     |        |
| 213-74-9902 Mary McKenna | 213-74-9902          |         | ---                         | Ho     |

Grantsville, MA. JUN 8 1979

Grantsville, MA. JUN 8 1979

Grantsville, MA. JUN 8 1979

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  | 7 1 3 8 1 7                                                                                                                                                                         |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  | REG. NO.                                                                                                                                                                            |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ISABELLE T. SCHAEFER</b>                                                                                                                                                                                                                                                         |  |                                                                                                                                       |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 14 79</b>                                                                                                                               |  | 2b. HOUR<br><b>6 55 P M</b>                                                                                                |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                           |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 7 1893</b>                                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>U.S.A. - MD.</b>                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b> MD.                                                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>STELLA MARIS HOSPICE</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                     |  | 13b. COUNTY<br><b>BALTO.</b>                                                                                                          |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                     |  | 13d. STREET ADDRESS<br><b>5005 BROADMOOR RD - 21212</b>                                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANDREW TUMBLESON</b>                                                                                                                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH TIGHE</b>                                                                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                          |  |                                                                                                                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-28-7182</b>                                                                                                                                                                                                                                                                                               |  | 17. INFORMANT<br><b>STELLA MARIS HOSPICE</b>                                                                                          |  | ADDRESS<br><b>2500 VALLEY RD 29, DULANEY 212</b>                                                                                                                                    |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CANCER OF COLON</b><br><b>1539</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>ADVANCED ASHD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                       |  |                                                                                                                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                         |  |                                                                                                                                       |  |                                                                                                                                                                                     |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                   |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                  |  |                                                                                                                                       |  |                                                                                                                                                                                     |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Eddie Nakhuda M.D.</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/14/79</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDDIE NAKHUDA M.D.</b>                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |  | 22e. ADDRESS<br><b>1205 YORK RD - 21093</b>                                                                                                                                         |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>6/18/79</b>                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>                                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. 1050 York Road</b>                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>                                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McBrady</b>                                                                       |  |

13311



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

| FOR<br>1 - STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                               |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |  |                                                                                                 |  | 7 9 1 3 8 1 8<br>REG. NO.                                                                                                                  |  |                                                                                                                            |  |                                                               |  |                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Scharf Henry</u>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                               |  |                                                                                                                                                             |  | FIRST                                                                                           |  | MIDDLE                                                                                                                                     |  | LAST                                                                                                                       |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>6/7/79</u>          |  | 2b. HOUR<br><u>10:30 P</u> M |  |
| 3. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><u>Caucasian</u>                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>5/23/07</u>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>72</u> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                             |  | IF UNDER 24 HRS<br>HOURS MIN.                                                                                              |  |                                                               |  |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Baltimore</u>                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                                                                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTO.</u> MD.                                       |  |                                                                                                                                            |  |                                                                                                                            |  |                                                               |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br><u>DUNDALK</u>                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Baltimore</u> |  |                                                                                                                                                             |  |                                                                                                 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Copper Industry</u>                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |                                                               |  |                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                     |  |                                                                                                                               |  |                                                                                                                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>2029 PAULETTE RD.</u>                                                                                            |  |                                                                                                                            |  |                                                               |  |                              |  |
| 13a. STATE<br><u>Baltimore</u>                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><u>BALTO</u>                                                                                                   |  | 13c. CITY OR TOWN<br><u>MD</u>                                                                                                                              |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |                                                               |  |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>GEORGE</u> <u>SCHARF</u>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>FRANCES</u> <u>MURPHY</u>                                                                               |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |                                                               |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><u>216-03-0847</u>                                                                                                              |  | 17. INFORMANT<br>ADDRESS<br><u>CATHERINE SCHARF ABOVE</u>                                       |  |                                                                                                                                            |  |                                                                                                                            |  |                                                               |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (d) <u>Cardiopulmonary Arrest</u><br><u>1540</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEPSIS</u><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>(c) <u>After resection for Carcinoma of Colon</u> |  |                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u> |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)                                                                                                                                                                                                                                                         |  |                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |                                                               |  |                              |  |
| 19a. DATE OF OPERATION<br><u>5/22/79</u>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Carcinoma of Colon and Rectum</u>                                                                    |  |                                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                               |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                    |  |                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>                                                                                           |  |                                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                            |  |                                                               |  |                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                              |  |                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  |                                                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |                                                               |  |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/2/79</u> , 19____, to <u>6/7/79</u> , 19____, that (I) (we) last saw the deceased alive on <u>6/7/79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                         |  |                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |                                                               |  |                              |  |
| 22b. SIGNATURE<br><u>Richard Ormewood</u>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                               |  |                                                                                                                                                             |  | DEGREE                                                                                          |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>6/12/79</u>                                                                                         |  |                                                               |  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Richard Ormewood</u>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                               |  |                                                                                                                                                             |  | 22e. ADDRESS<br><u>Johns Hopkins Hospital</u>                                                   |  |                                                                                                                                            |  |                                                                                                                            |  |                                                               |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                               |  | 23b. DATE<br><u>6-11-79</u>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>SACRED HT. OF JESUS</u>                                |  |                                                                                                                                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>DUNDALK BALTO MD</u>                                                      |  |                                                               |  |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>CONNELLY F.H.</u>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                               |  |                                                                                                                                                             |  | ADDRESS<br><u>300 WACE AVE</u>                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 14 1979</u>                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><u>P. K. [Signature]</u>                                                                     |  |                                                               |  |                              |  |



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OFFICE OF THE  
DIRECTOR, BUREAU OF  
LAND MANAGEMENT  
WASHINGTON, D.C. 20013

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SUBJECT: [illegible]  
DATE: [illegible]  
[illegible text follows, including various lines of a memorandum format]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 13819

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                |                                                                                                                                           |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>CLARENCE C. SCHUCHHARDT                                                                                                                                                                                                                                                                                              |  |                                                                                                                                | 2a. DATE OF DEATH MONTH DAY YEAR<br>JUNE 2 1979                                                                                           |                                                                                                                                                             | 2b. HOUR<br>10:30 P.M.                                                         |                                                                           |                                                                                                 |                                                                                                                            |                                             |  |
| 3. SEX<br>M.                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>WHITE                                                                                                               |                                                                                                                                           | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 2 1901                                                                                                                 |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                |                                                                                                 | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                 |                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>35 MARYLAND                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |                                                                                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.              |                                                                                                 |                                                                                                                            |                                             |  |
| 10. CITY OR TOWN OF DEATH<br>10 MIDDLE RIVER                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>917 COLD SPRING ROAD |                                                                                                                                           | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MECHANIC                                                                                   |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>AUTO                                 |                                                                                                 |                                                                                                                            |                                             |  |
| 13a. STATE<br>35 MARYLAND                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                | 13b. COUNTY<br>BALTIMORE                                                                                                                  |                                                                                                                                                             | 13c. CITY OR TOWN<br>MIDDLE RIVER                                              |                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br>917 COLD SPRING ROAD |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>30 AUGUST SCHUCHHARDT                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>KATIE EKAS                                                                                  |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>213-05-8295                                                                                                   |                                                                                                                                                             | 17. INFORMANT ADDRESS<br>FAMILY RECORDS                                        |                                                                           |                                                                                                 |                                                                                                                            |                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic cancer</u><br>185-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cancer bladder</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cancer prostate</u>                                                                              |  |                                                                                                                                |                                                                                                                                           |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u><br><u>2 years</u><br><u>2 years</u>                          |                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                              |  |                                                                                                                                |                                                                                                                                           |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                             |  |
| 19a. DATE OF OPERATION<br>9 9                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                      |  |                                                                                                                                | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                   |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                           |                                                                                                 |                                                                                                                            |                                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                        |  |                                                                                                                                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                       |                                                                                                                                                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                           |                                                                                                 |                                                                                                                            |                                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/29</u> 19 <u>58</u> to <u>5/31</u> 19 <u>79</u> , that (I) <u>lost</u> saw the deceased alive on <u>5/31</u> 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I <u>was</u> <u>not</u> ) (did not) view the body after death. |  |                                                                                                                                |                                                                                                                                           |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                             |  |
| 22b. SIGNATURE<br><u>L. K. Kolodny</u>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                                                             |                                                                                | 22c. DATE SIGNED<br><u>6/4/79</u>                                         |                                                                                                 |                                                                                                                            |                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LEWIS A. KOLODNY                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                | 1825 EASTERN BLVD.                                                                                                                        |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                | 23b. DATE<br>6-6-1979                                                                                                                     |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEM.                            |                                                                           | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>PARKVILLE BALTO. MD.                                 |                                                                                                                            |                                             |  |
| 24. FUNERAL DIRECTOR NAME<br>EVANS FUNERAL CHAPEL                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                | ADDRESS<br>8800 HARFORD RD.                                                                                                               |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 11 1979                                   |                                                                           | 25b. REGISTRAR'S SIGNATURE<br><u>L. K. Kolodny</u>                                              |                                                                                                                            |                                             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77  
(VRA 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                     |  |                                                                                                                                                          |                                                                                   |                                                                                              |                                                                                                                         |                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                     |  |                                                                                                                                                          | REG. NO. 79 13820                                                                 |                                                                                              |                                                                                                                         |                                                |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BABY BOY SCHWIEGERATH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |  |                                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 4, 1979</b>                              |                                                                                              |                                                                                                                         | 2b. HOUR <b>8:30 a.m.</b>                      |  |
| 3. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE <b>WHITE</b>                                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 4 1979</b>                                                                                                       |                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>2 9</b>                                  |                                                                                                                         | IF UNDER 1 YEAR IF UNDER 24 HRS.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>                             |                                                                                                                         |                                                |  |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT JOSEPH HOSPITAL</b> |  |                                                                                                                                                          |                                                                                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>---</b>                     |                                                                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                     |  |                                                                                                                                                          |                                                                                   |                                                                                              |                                                                                                                         |                                                |  |
| 13a. STATE <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY <b>Harford</b>                                                                                                          |  | 13c. CITY OR TOWN <b>Forest Hill</b>                                                                                                                     |                                                                                   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                         | 13e. STREET ADDRESS <b>1306 Turnbridge Rd.</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael R. Schwiegerath</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     |  |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Patricia L. Mihavetz</b>            |                                                                                              |                                                                                                                         |                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>---</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO. <b>---</b>                                                                                                 |  | 17. INFORMANT ADDRESS <b>---</b>                                                                                                                         |                                                                                   |                                                                                              |                                                                                                                         |                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> <b>7651</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>---</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>---</b> DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                |  |                                                                                                                                     |  |                                                                                                                                                          |                                                                                   |                                                                                              |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>---</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |  |                                                                                                                                                          |                                                                                   |                                                                                              |                                                                                                                         |                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |  |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                                   |                                                                                              |                                                                                                                         |                                                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                   |                                                                                              |                                                                                                                         |                                                |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 4</b> , 19 <b>79</b> , to <b>June 4</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 4</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death. |  |                                                                                                                                     |  |                                                                                                                                                          |                                                                                   |                                                                                              |                                                                                                                         |                                                |  |
| 22b. SIGNATURE <b>Heng Ke</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     |  |                                                                                                                                                          | 22c. DATE SIGNED <b>6/4/79</b>                                                    |                                                                                              |                                                                                                                         |                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Heng Ke, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     |  |                                                                                                                                                          | 22e. ADDRESS <b>7620 York Rd., Towson, MD 21204</b>                               |                                                                                              |                                                                                                                         |                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Released to Hosp.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE <b>June 4, 1979</b>                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Hospital</b>                                                                                            |                                                                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Towson, Balto., MD</b>                            |                                                                                                                         |                                                |  |
| 24. FUNERAL DIRECTOR NAME <b>Ray G. Cant</b> ADDRESS <b>7620 York Rd., Towson, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     |  |                                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1979</b>                                  |                                                                                              | 25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>                                                                       |                                                |  |

BP

U S S R 1 2 3 4

OFFICE OF THE SECRETARY OF DEFENSE  
WASHINGTON, D. C. 20301



TO HOSPITAL OR ATTENDING PHYSICIAN: The patient is retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health officer, and page 3 should be filed with the State Health Department. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| STATE OF MARYLAND                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                      |                                                                                                                                                          |                                                                     |                                      |                                   |                 |                   |                 |                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------|-----------------------------------|-----------------|-------------------|-----------------|----------------|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                      |                                                                                                                                                          |                                                                     |                                      |                                   |                 |                   |                 |                |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                      |                                                                                                                                                          |                                                                     |                                      |                                   |                 |                   |                 |                |
| REG. NO. 13821                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                      |                                                                                                                                                          |                                                                     |                                      |                                   |                 |                   |                 |                |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                        | FIRST                                                                                                                                                |                                                                                                                                                          | MIDDLE                                                              |                                      | LAST                              |                 | 2a. DATE OF DEATH |                 | MONTH DAY YEAR |
| Viola                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                      |                                                                                                                                                          | Scribner                                                            |                                      |                                   |                 | 06 11 79          |                 | 1615 A. M.     |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                     | 4. RACE                                                                                                                                              | 5. DATE OF BIRTH                                                                                                                                         |                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)      |                                   | IF UNDER 1 YEAR |                   | IF UNDER 24 HRS |                |
| Female                                                                                                                                                                                                                                                                                                                                                                                     | Negro                                                                                                                                                | MONTH DAY YEAR<br>07 10 01                                                                                                                               |                                                                     | 77 YRS.                              |                                   | MONTHS DAYS     |                   | HOURS MIN.      |                |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                   |                 |                   |                 |                |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                  | U.S.                                                                                                                                                 |                                                                                                                                                          |                                                                     | Baltimore County                     |                                   |                 |                   | MD              |                |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                            |                                                                                                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |                                      | 12b. KIND OF BUSINESS OR INDUSTRY |                 |                   |                 |                |
| Catonsville                                                                                                                                                                                                                                                                                                                                                                                | House in the Pines - Catonsville                                                                                                                     |                                                                                                                                                          | DYER                                                                |                                      | CLEANING Plant                    |                 |                   |                 |                |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                 | 13b. COUNTY                                                                                                                                          | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS                  |                                   |                 |                   |                 |                |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                      | Baltimore                                                                                                                                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 2040 Northeast Avenue                |                                   |                 |                   |                 |                |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME                                                                                                                             |                                                                                                                                                          |                                                                     |                                      |                                   |                 |                   |                 |                |
| FIRST MIDDLE LAST<br>Luther Wesley                                                                                                                                                                                                                                                                                                                                                         | FIRST MIDDLE LAST<br>Pulley                                                                                                                          |                                                                                                                                                          |                                                                     |                                      |                                   |                 |                   |                 |                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                       | 16b. SOCIAL SECURITY NO.                                                                                                                             | 17. INFORMANT                                                                                                                                            |                                                                     | ADDRESS                              |                                   |                 |                   |                 |                |
| NO                                                                                                                                                                                                                                                                                                                                                                                         | 212-44-6794                                                                                                                                          | House in the Pines                                                                                                                                       |                                                                     | Baltimore, Md.                       |                                   | 21228           |                   |                 |                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct.</u><br>410- DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C.V.A.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis.</u> | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr.<br>235.<br>1037                                                                                |                                                                                                                                                          |                                                                     |                                      |                                   |                 |                   |                 |                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                        |                                                                                                                                                      |                                                                                                                                                          |                                                                     |                                      |                                   |                 |                   |                 |                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     | 20a. AUTOPSY?                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                      |                                   |                 |                   |                 |                |
|                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                      |                                   |                 |                   |                 |                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                     |                                      |                                   |                 |                   |                 |                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |                                                                     |                                      |                                   |                 |                   |                 |                |
| 22a. I certify that (I) (husband) attended the deceased from April 6, 1977, to June 11, 1979, that (I) (we) last saw the deceased alive on June 9, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                                                                |                                                                                                                                                      |                                                                                                                                                          |                                                                     |                                      |                                   |                 |                   |                 |                |
| 22b. SIGNATURE<br>Wilmer K. Gallagher, Jr. M.D.                                                                                                                                                                                                                                                                                                                                            | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>6-11-79                                                                                                                              |                                                                     |                                      |                                   |                 |                   |                 |                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Wilmer K. Gallagher, Jr. M.D.                                                                                                                                                                                                                                                                                                                     | 22e. ADDRESS<br>6209 Frederick St. Baltimore, Md. 21228                                                                                              |                                                                                                                                                          |                                                                     |                                      |                                   |                 |                   |                 |                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                               | 23b. DATE                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                                      |                                   |                 |                   |                 |                |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                     | JUNE 16, 79                                                                                                                                          | ARBUS MEM. PARK                                                                                                                                          | BALTIMORE County Md.                                                |                                      |                                   |                 |                   |                 |                |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                       | 25a. DATE REC'D. BY REGISTRAR                                                                                                                        | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |                                                                     |                                      |                                   |                 |                   |                 |                |
| HERBERT E. NUTTER 3035 W. North Ave.                                                                                                                                                                                                                                                                                                                                                       | JUN 19 1979                                                                                                                                          | [Signature]                                                                                                                                              |                                                                     |                                      |                                   |                 |                   |                 |                |



1 3 8 2 1

UNITED STATES OF AMERICA

HENRY E. WILKINSON  
JAN 1 1919  
BOSTON, MASS.  
JAN 1 1919



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                      |                                                             |                                                                                                                                                             |                                                                                              |                                                                             |                                                                                                                         |                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7-9 13822                                                                                                                                            |                                                             |                                                                                                                                                             |                                                                                              | REG. NO.                                                                    |                                                                                                                         |                                                               |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ruth Ide SEIDLER                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                      | 2a. DATE OF DEATH MONTH DAY YEAR<br>JUNE 10, 1979           |                                                                                                                                                             |                                                                                              | 2b. HOUR<br>8:30 P.M.                                                       |                                                                                                                         |                                                               |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br>White                                                                                                                                      |                                                             | 5. DATE OF BIRTH MONTH DAY YEAR<br>Mar. 29, 1913                                                                                                            |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                  |                                                                                                                         | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                  |                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                |                                                                                                                         |                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>Lutherville                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>College Manor Nursing Home                 |                                                             |                                                                                                                                                             |                                                                                              | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor |                                                                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY<br>American Oil Co.         |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                      | 13c. CITY OR TOWN<br>Baltimore                              |                                                                                                                                                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                             | 13e. STREET ADDRESS<br>243 Rodgers Forge Road                                                                           |                                                               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Louis T. Seidler                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                      | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sophie Schupp |                                                                                                                                                             |                                                                                              |                                                                             |                                                                                                                         |                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>265 26 9343                                                                                                              |                                                             | 17. INFORMANT ADDRESS<br>Dr. A. LePage Seidler Balto., Md.                                                                                                  |                                                                                              |                                                                             |                                                                                                                         |                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br>3310<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alzheimer's Syndrome</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hrs<br>Years |  |                                                                                                                                                      |                                                             |                                                                                                                                                             |                                                                                              |                                                                             |                                                                                                                         |                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                      |                                                             |                                                                                                                                                             |                                                                                              |                                                                             |                                                                                                                         |                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |                                                             |                                                                                                                                                             | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                              |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                              |                                                                             |                                                                                                                         |                                                               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                  |                                                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                                              |                                                                             |                                                                                                                         |                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 5</u> , 19 <u>79</u> , to <u>June 10</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 2</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                             |  |                                                                                                                                                      |                                                             |                                                                                                                                                             |                                                                                              |                                                                             |                                                                                                                         |                                                               |  |
| 22b. SIGNATURE<br><u>William J Fritz</u>                                                                                                                                                                                                                                                                                                                                                                                                              |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                             |                                                                                                                                                             |                                                                                              | 22c. DATE SIGNED<br>6/11/79                                                 |                                                                                                                         |                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. William Fritz, M.D.                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                      |                                                             | 22e. ADDRESS<br>2 W. University Pkwy. Balto., Md.                                                                                                           |                                                                                              |                                                                             |                                                                                                                         |                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>6-13-79                                                                                                                                 |                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn                                                                                                              |                                                                                              | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Woodlawn Baltimore Md.           |                                                                                                                         |                                                               |  |
| 24. FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                      |                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 11 1979                                                                                                                |                                                                                              | 25b. REGISTRAR'S SIGNATURE<br><u>Hickory McBrady</u>                        |                                                                                                                         |                                                               |  |

22001



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 3 8 2 3

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                   |                                                             |                                                                                    |                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HURDIE LEROY SEWELL</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 23, 1979</b> |                                                                                    | 2b. HOUR<br><b>10:45 PM</b> |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>Negro</b>                                                                                                                           |                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10/2/21</b>                               |                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                           |                                                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                      |                             |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                                                                      |                                                             |                                                                                    |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN HOME FACILITY, GIVE STREET ADDRESS)<br><b>GREATER BALTO. MEDICAL CENTER</b> |                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |                             |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govern.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                          |                                                             | 13b. COUNTY<br><b>A.A. Co.</b>                                                     |                             |  |
| 13c. CITY OR TOWN<br><b>Harmon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                   |                                                             | 13e. STREET ADDRESS<br><b>1405 Dorsey Road</b>                                     |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Harrison</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Roberta Harrison</b>                                                                          |                                                             |                                                                                    |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>W.W. 11</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-12-3788</b>                                                                     |                                                             | 17. INFORMANT<br>ADDRESS<br><b>Ethel R. Sewell 1405 Dorsey Rd.</b>                 |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |                                                                                                                                                   |                                                             |                                                                                    |                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                  |                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                 |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |                             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                            |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |                             |  |
| 22a. certify that (I, this hospital) attended the deceased from <b>JUNE 23, 1979</b> to <b>JUNE 23, 1979</b> , that (I) (we) lost saw the deceased die on <b>JUNE 23, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>Booth</b> did not view the body after death.                                                                                                                                                                          |  |                                                                                                                                                   |                                                             |                                                                                    |                             |  |
| 22b. SIGNATURE<br><b>F.V. Mc Booth</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | DEGREE<br><b>Booth</b>                                                                                                                            |                                                             | 22c. DATE SIGNED<br><b>JUNE 24, 79</b>                                             |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>F.V. Mc Booth</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS<br><b>6701 NORTH CHARLES ST. 21204</b>                                                                                               |                                                             |                                                                                    |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>6/27/79</b>                                                                                                                       |                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Saint Rest Cem.</b>                       |                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Harmon A.A. Co. Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles A. Rice</b>                                                                                            |                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>                                |                             |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Barney K. K...</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                   |                                                             |                                                                                    |                             |  |

BP

1 3 0 0 1

DATE: 10/12/72

10/12/72

10/12/72

10/12/72

10/12/72

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

RE: [illegible]

DATE: 10/12/72

TO: DIRECTOR, FBI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                        |        | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                   |  | 7 9 1 3 8 2 4                                                                                                                                           |  | REG. NO.                                                       |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                               |        | FIRST MIDDLE LAST                                                                                      |  | 2a. DATE OF DEATH                                                                                                                                       |  | MONTH DAY YEAR HOUR                                            |                                              |
| Mary E. V. Shearer.                                                                                                                                                                                                                                                                                            |        |                                                                                                        |  | 06 30 79                                                                                                                                                |  | 8:00 PM                                                        |                                              |
| 3 SEX                                                                                                                                                                                                                                                                                                          | 4 RACE | 5. DATE OF BIRTH                                                                                       |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                                                                          |  | IF UNDER 1 YEAR                                                |                                              |
| Female                                                                                                                                                                                                                                                                                                         | C.     | MONTH DAY YEAR                                                                                         |  | 76                                                                                                                                                      |  | MONTHS DAYS HOURS MIN.                                         |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                      |        | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                            |                                              |
| ?                                                                                                                                                                                                                                                                                                              |        | U.S.                                                                                                   |  |                                                                                                                                                         |  | BALTO. CO. MD.                                                 |                                              |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                       |        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                      |        | BCGH                                                                                                   |  | NURSE                                                                                                                                                   |  | RETIRED                                                        |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                        |        |                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                                                                                                                |  | 13e. STREET ADDRESS                                            |                                              |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN                                                                                                                                                                                                                                                                       |        |                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                     |  | 413 UPLAND RD.                                                 |                                              |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)                                                                                                                                                                                                                                                                          |        |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                                                                                                            |  |                                                                |                                              |
| DAVID SHEARER                                                                                                                                                                                                                                                                                                  |        |                                                                                                        |  | ROSEANNE ROBERTSON                                                                                                                                      |  |                                                                |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                              |        | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT                                                                                                                                           |  | ADDRESS                                                        |                                              |
| YES                                                                                                                                                                                                                                                                                                            |        | WWT 215-32-8143                                                                                        |  | ANNE S. BAILEY                                                                                                                                          |  | SAME                                                           |                                              |
| 18 CAUSE OF DEATH (Enter only one cause primary for (a), (b), and (c).)                                                                                                                                                                                                                                        |        |                                                                                                        |  |                                                                                                                                                         |  |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                   |        |                                                                                                        |  |                                                                                                                                                         |  |                                                                | 24 hrs                                       |
| IMMEDIATE CAUSE (a) SEVERE dehydration.                                                                                                                                                                                                                                                                        |        |                                                                                                        |  |                                                                                                                                                         |  |                                                                |                                              |
| DUE TO OR AS A CONSEQUENCE OF (b) POSSIBLE HIDDEN GI malignancy                                                                                                                                                                                                                                                |        |                                                                                                        |  |                                                                                                                                                         |  |                                                                |                                              |
| DUE TO OR AS A CONSEQUENCE OF (c) Internal bleeding (2) Aspiration pneumonia                                                                                                                                                                                                                                   |        |                                                                                                        |  |                                                                                                                                                         |  |                                                                | 24 hrs                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                            |        |                                                                                                        |  |                                                                                                                                                         |  |                                                                |                                              |
| Partial intestinal obstruction                                                                                                                                                                                                                                                                                 |        |                                                                                                        |  |                                                                                                                                                         |  |                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                         |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                              |
|                                                                                                                                                                                                                                                                                                                |        |                                                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                             |        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                          |  |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                                |        | P.M. 19                                                                                                |  |                                                                                                                                                         |  |                                                                |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME                                                                                                                                                                                |        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                                |        |                                                                                                        |  |                                                                                                                                                         |  |                                                                |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/30/19 79 to 6/30/19 79, that (I) (we) lost saw the deceased alive on 6/30/19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |        |                                                                                                        |  |                                                                                                                                                         |  |                                                                |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                 |        | 22c. DATE SIGNED                                                                                       |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                   |  | 22e. ADDRESS                                                   |                                              |
| Bureford                                                                                                                                                                                                                                                                                                       |        | 6/30/79                                                                                                |  | N.J. Suresha                                                                                                                                            |  | BCGH                                                           |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                      |        | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |                                              |
| CREMATION                                                                                                                                                                                                                                                                                                      |        | 7-2-79                                                                                                 |  | WASTVIEW MEM                                                                                                                                            |  | BALTO. CO. MD.                                                 |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                      |        |                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                           |  | 25b. REGISTRAR'S SIGNATURE                                     |                                              |
| Frank A. Newell, Inc. Pikesville, Md.                                                                                                                                                                                                                                                                          |        |                                                                                                        |  | JUL 5 1979                                                                                                                                              |  | Kristy McCreedy                                                |                                              |

BP

13031 00

RECEIVED  
JUL 2 1954

TO: Mr. J. Edgar Hoover  
FROM: Mr. J. Edgar Hoover

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

MAILED  
JUL 2 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  | REG. NO. 9 13825                                                                                                                                            |  |                                                                                                                         |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>WILLIAM E SHIPLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 5, 1979</b>                                                                                                     |  |                                                                                                                         |                                              |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>White</b>                                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 23, 1899</b>                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>80 YRS</b>                                                 |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                                                     |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SAINT JOSEPH HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>                                                                    |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland Baltimore 21239</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                |  | 13e. STREET ADDRESS<br><b>6934 Donachie Road</b>                                                                        |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Samuel P. Shipley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ida M. Andrews</b>                                                                                         |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>W.W. I 705-05-7989</b>                                                      |  | 17. INFORMANT ADDRESS<br><b>Robert L. Shipley 4627 Live Oak Et. 21043</b>                                                                                   |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute CVA</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Emphysema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Pneumonia</b> |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |                                              |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>MAY 4, 1979</b> , to <b>JUNE 5, 1979</b> , that (b) (we) last saw the deceased alive on <b>JUNE 5, 1979</b> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so state.)                                                                                                                                                                                                                |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 22b. SIGNATURE DEGREE<br><b>Thomas K. Polivka</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>6/5/79</b>                                                                                       |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS K. POLIVKA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  | 22e. ADDRESS<br><b>2926 E. Cold Spring Lane, Balto., MD 21214</b>                                                                                           |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>June 8, '79</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>                                                                                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., MD</b>                                                     |                                              |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>William E. Johnson 8521 Loch Raven Blvd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 7 1979</b>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia M. Brady</b>                                                                  |                                              |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Her death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                               |  |                                                                                                                                             |  |                                                                                                                                                             |                                                                        |                                                                                                                                                   |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR Charles L Showalter                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |  |                                                                                                                                                             |                                                                        |                                                                                                                                                   |  |                                                                                                                            |  |
| REG. NO. 79 13826                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |  |                                                                                                                                                             |                                                                        |                                                                                                                                                   |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>CHARLES L. SHOWALTER                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |  |                                                                                                                                                             |                                                                        | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 6/1/79                                                                                                   |  | 2b. HOUR<br>5:40 AM                                                                                                        |  |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>2 White                                                                                                                          |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 29 1906                                                                                                             |                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS                                                                                                         |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                                                                       |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hospital |  |                                                                                                                                                             |                                                                        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mixer                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Paint Co.                                                                             |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |                                                                                                                                                             |                                                                        |                                                                                                                                                   |  |                                                                                                                            |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br>---                                                                                                                          |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                   |  | 13e. STREET ADDRESS<br>5033 Frederick Avenue 21229                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Milton Thomas Showalter                                                                                                                                                                                                                                                                                     |  |                                                                                                                                             |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Catherine Veronica Smith |                                                                                                                                                   |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>212-10-1602                                                                                                     |  | 17. INFORMANT ADDRESS<br>A Ruth Brankovich/310 S Woodyear St/21223                                                                                          |                                                                        |                                                                                                                                                   |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause, per the form (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Intra-abdominal hemorrhage<br>584- DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Acute Renal Failure |  |                                                                                                                                             |  |                                                                                                                                                             |                                                                        |                                                                                                                                                   |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                 |  |                                                                                                                                             |  |                                                                                                                                                             |                                                                        |                                                                                                                                                   |  |                                                                                                                            |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |  |                                                                                                                                                             |                                                                        |                                                                                                                                                   |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |  |                                                                                                                                                             |                                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                        |                                                                                                                                                   |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                        |                                                                                                                                                   |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/31/79 to 6/1/79, that (I) (we) lost the deceased alive on 6/1/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                    |  |                                                                                                                                             |  |                                                                                                                                                             |                                                                        |                                                                                                                                                   |  |                                                                                                                            |  |
| 22b. SIGNATURE Bernabe Jr MD                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |  |                                                                                                                                                             |                                                                        | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>6/1/79                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BERNARDO D. GONZALES                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |  | 22e. ADDRESS<br>BALTIMORE COUNTY GEN. HOS.                                                                                                                  |                                                                        |                                                                                                                                                   |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>06/05/79                                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                                                                                                   |                                                                        | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Anne Arundel Co., Maryland                                                                             |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR NAME<br>Walters Funeral Home/Pratt & Stricker Streets                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |  | ADDRESS<br>21223                                                                                                                                            |                                                                        | 25a. DATE REC'D. BY REGISTRAR<br>JUN 1 1979                                                                                                       |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McNeely                                                                              |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                |         |                                                                                                                                     |                   |                                                                                                                                                             |                     |                                                                                 |                                       |                                                                               |                                               |                                                                                     |  | REG. NO. 13827                                         |                                |                                                                                      |                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------|--|--------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------|------------------------------------------|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                                                                                     |                   |                                                                                                                                                             |                     |                                                                                 |                                       |                                                                               |                                               |                                                                                     |  | 2a. DATE KNOWN OF DEATH                                | 2b. HOUR                       |                                                                                      |                                          |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>WALTER J. SINGLETON                                                                                                                                                                                                                                                                                                                                                                              |         |                                                                                                                                     |                   |                                                                                                                                                             |                     |                                                                                 |                                       |                                                                               |                                               |                                                                                     |  | DATE ESTIMATED<br>June 7 1979                          | 24 PM                          |                                                                                      |                                          |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE | 5. DATE OF BIRTH                                                                                                                    | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR.                                                                                                                                           | 8. IF UNDER 24 HRS. | 9. DATE PRONOUNCED DEAD                                                         | 10. BALTIMORE CITY OR COUNTY OF DEATH |                                                                               |                                               |                                                                                     |  | 2d. HOUR                                               |                                |                                                                                      |                                          |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                                   | White   | Feb 2, 1902                                                                                                                         | 77 YRS.           |                                                                                                                                                             |                     | June 7 1979                                                                     | Baltimore County MD                   |                                                                               |                                               |                                                                                     |  | 24 PM                                                  |                                |                                                                                      |                                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                  |         | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                              |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County                        |                                       |                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br>Smelting |                                                                                     |  |                                                        |                                |                                                                                      |                                          |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                                                                                    |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph's Hospital |                   |                                                                                                                                                             |                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Special Police |                                       |                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br>American |                                                                                     |  |                                                        |                                |                                                                                      |                                          |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                                                                                     |                   |                                                                                                                                                             |                     |                                                                                 |                                       |                                                                               |                                               |                                                                                     |  | 13b. COUNTY<br>Baltimore                               | 13c. CITY OR TOWN<br>Baltimore | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1707 Sherwood Ave |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Singleton                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                                                     |                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Florence Gardiner                                                                                          |                     |                                                                                 |                                       |                                                                               |                                               |                                                                                     |  |                                                        |                                |                                                                                      |                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                            |         |                                                                                                                                     |                   | 16b. SOCIAL SECURITY NO.<br>218-01-6331                                                                                                                     |                     | 17. INFORMANT<br>Mrs Thelma Ann Singleton                                       |                                       |                                                                               | ADDRESS<br>Same                               |                                                                                     |  |                                                        |                                |                                                                                      |                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Generalized ASVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                                                |         |                                                                                                                                     |                   |                                                                                                                                                             |                     |                                                                                 |                                       |                                                                               |                                               |                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Sudden |                                |                                                                                      |                                          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                    |         |                                                                                                                                     |                   |                                                                                                                                                             |                     |                                                                                 |                                       |                                                                               |                                               |                                                                                     |  |                                                        |                                |                                                                                      |                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                                                                                     |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |                     |                                                                                 |                                       |                                                                               |                                               | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                        |                                |                                                                                      |                                          |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                              |         |                                                                                                                                     |                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                     |                                                                                 |                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                               |                                                                                     |  |                                                        |                                |                                                                                      |                                          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |         |                                                                                                                                     |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                 |                     |                                                                                 |                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                               |                                                                                     |  |                                                        |                                |                                                                                      |                                          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |                                                                                                                                     |                   |                                                                                                                                                             |                     |                                                                                 |                                       |                                                                               |                                               |                                                                                     |  |                                                        |                                |                                                                                      |                                          |
| ACTUAL SIGNATURE<br>Charles F O'Donnell                                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                                                                                     |                   | TITLE (SPECIFY)<br>M.D. Deputy                                                                                                                              |                     |                                                                                 |                                       | DATE SIGNED<br>6/7/79                                                         |                                               |                                                                                     |  |                                                        |                                |                                                                                      |                                          |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Charles F O'Donnell                                                                                                                                                                                                                                                                                                                                                                                              |         |                                                                                                                                     |                   | ADDRESS<br>7501 York Rd Towson, Maryland                                                                                                                    |                     |                                                                                 |                                       |                                                                               |                                               |                                                                                     |  |                                                        |                                |                                                                                      |                                          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                                                                                     |                   | 23b. DATE<br>6/11/79                                                                                                                                        |                     | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood                                  |                                       |                                                                               |                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                   |  |                                                        |                                |                                                                                      |                                          |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc.                                                                                                                                                                                                                                                                                                                                                                                                  |         |                                                                                                                                     |                   |                                                                                                                                                             |                     | ADDRESS<br>5305 Harford Road 21214                                              |                                       | 25a. DATE REC'D. BY REGISTRAR<br>JUN 12 1979                                  |                                               | 25b. REGISTRAR'S SIGNATURE<br>Ruthy McBrady                                         |  |                                                        |                                |                                                                                      |                                          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |                                                                     |                                                                                                                                                             |                                                                                                                                            |                                                                                      |                                                            |                                                                                                                            |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                     |  | 9 1 3 8 2 8<br>REG. NO.                                                                                                          |                                                                     |                                                                                                                                                             |                                                                                                                                            |                                                                                      |                                                            |                                                                                                                            |                                                                                                 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>PATRICIA L. SIRETT</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  |                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JUNE 4 1979</b>                                                                                     |                                                                                      | 2b. HOUR P M<br><b>11:30 P M</b>                           |                                                                                                                            |                                                                                                 |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>W</b>                                                                                                              |                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4-30-1935</b>                                                                                                         |                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>44</b> YRS                                     |                                                            | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN                                                                |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ENGLAND</b>                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>ENGLAND</b>                                                                                   |                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CO MD.</b>                          |                                                            |                                                                                                                            |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cub Hill</b>                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>9378 Penridge Rd</b> |                                                                     |                                                                                                                                                             |                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tailoring</b> |                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>clothing</b>                                                                       |                                                                                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                  |                                                                     |                                                                                                                                                             | 13b. COUNTY<br><b>BALTO</b>                                                                                                                |                                                                                      | 13c. CITY OR TOWN<br><b>Cub Hill</b>                       |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>PATRICK G. LITNAME</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ALICE</b>                                                                                 |                                                                                      |                                                            |                                                                                                                            |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>                             |                                                                                                                                                             | 17. INFORMANT ADDRESS<br><b>NeFFery SIRETT 9378 Penridge Rd</b>                                                                            |                                                                                      |                                                            |                                                                                                                            |                                                                                                 |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1749</b> IMMEDIATE CAUSE (a) <b>Mitralgia originaria of heart 34mm</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |                                                                                                                                  |                                                                     |                                                                                                                                                             |                                                                                                                                            |                                                                                      |                                                            |                                                                                                                            |                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                                        |  |                                                                                                                                  |                                                                     |                                                                                                                                                             |                                                                                                                                            |                                                                                      |                                                            |                                                                                                                            |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                             |                                                                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |  |                                                                                                                                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                      |                                                            |                                                                                                                            |                                                                                                 |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                           |  |                                                                                                                                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                             |                                                                                      |                                                            |                                                                                                                            |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>ADD.</b> 19 <b>78</b> to <b>June</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Dec</b> 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |                                                                                                                                  |                                                                     |                                                                                                                                                             |                                                                                                                                            |                                                                                      |                                                            |                                                                                                                            |                                                                                                 |  |
| 22b. SIGNATURE <b>[Signature]</b> DEGREE <b>M.D.</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |                                                                     |                                                                                                                                                             | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                      |                                                            | 22c. DATE SIGNED<br><b>6/5/79</b>                                                                                          |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. ELLIOTT HARRIS</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                  |                                                                     |                                                                                                                                                             | 22e. ADDRESS<br><b>8100 HARFORD RD</b>                                                                                                     |                                                                                      |                                                            |                                                                                                                            |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  | 23b. DATE<br><b>6/5/79</b>                                          |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Nesview Memorial</b>                                                                              |                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b> |                                                                                                                            |                                                                                                 |  |
| 24. FUNERAL DIRECTOR NAME<br><b>EVANS FUNERAL CHAPEL</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                  |                                                                     |                                                                                                                                                             | ADDRESS<br><b>8800 HARFORD RD</b>                                                                                                          |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 11 1979</b>        |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                |  |

MEDICAL CERTIFICATION



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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                      |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |                                                                        |                                                                                                                                                             | 7 9 1 3 8 2 9<br>REG. NO.                                                                                                                            |                                                                                                 |                                                                      |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>ALICE E. SMITH                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>J <sup>U</sup> ne 25, 1979                                                                                                      |                                                                                                 |                                                                      | 2b. HOUR<br>9 <sup>12</sup> M                                                                                              |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>White                                                                                                                  |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 6, 1894                                                                                                          |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS                                                       |                                                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |                                                                      |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Summitt Nursing Home |                                                                        |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br>Howard                                                                                                             |                                                                        | 13c. CITY OR TOWN<br>Ellicott City                                                                                                                          |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                      | 13e. STREET ADDRESS<br>8079 Old Montgomery Road                                                                            |  |
| 14. FATHER'S NAME<br>First MIDDLE LAST<br>late Clarence Leighter                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>First MIDDLE LAST<br>late Deborah                                                                                        |                                                                                                 |                                                                      |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                   | 16b. SOCIAL SECURITY NO.                                               |                                                                                                                                                             | 17. INFORMANT ADDRESS<br>Mrs Wnada Mulkey 8039 Old Montgomery Road 21043                                                                             |                                                                                                 |                                                                      |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Crown Thrombosis</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arterio Sclerotic Vase Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>As</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Instantaneous</u><br><u>unknown</u> |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                      |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                          |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                      |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                     |  |                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                                 |                                                                      |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                    |  |                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                                 |                                                                      |                                                                                                                            |  |
| 22a. I certify that (we) (this hospital) attended the deceased from <u>10/1/76</u> , 19 <u>76</u> , to <u>6/25</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (we) (did not) view the body after death.                  |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                      |                                                                                                                            |  |
| 22b. SIGNATURE<br>CLIFF KATHIFF, JR., M.D.                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                   |                                                                        |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 |                                                                      | 22c. DATE SIGNED<br>6-25-79                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CLIFF KATHIFF, JR., M.D.                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                   |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br>5772 WESTVIEW MARK<br>BALTIMORE, MD., 21228                                                                                          |                                                                                                 |                                                                      |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   | 23b. DATE<br>June 27'79                                                |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadoeridge                                                                                                    |                                                                                                 | 23d. LOCATION<br>City or Town County State<br>Dorsey Howard Maryland |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Harry H Witzke 4112 Columbia Road Ellicott City                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                   |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 28 1979                                                                                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreedy                       |                                                                                                                            |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                         |  | 7 9 1 3 8 3 0<br>REG. NO.                                                                              |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                            |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                  |  | LAST                                                                                         |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                        |  | 2b. HOUR                                     |  |
| MARY                                                                                                                                                                                                                                                                                                           |  | E.                                                                                                     |  | SMITH                                                                                                                                                   |  |                                                                                              |  | 6-21-79                                                                                                                 |  | 10 <sup>15</sup> M                           |  |
| 3 SEX                                                                                                                                                                                                                                                                                                          |  | 4 RACE                                                                                                 |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                              |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |  | IF UNDER 27 HRS. HOURS MIN.                  |  |
| FEMALE                                                                                                                                                                                                                                                                                                         |  | WHITE                                                                                                  |  | 05 05 92                                                                                                                                                |  | 87 YRS.                                                                                      |  |                                                                                                                         |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                          |  |                                                                                                                         |  |                                              |  |
| ILLINOIS                                                                                                                                                                                                                                                                                                       |  | U.S.A.                                                                                                 |  |                                                                                                                                                         |  | BALTIMORE COUNTY MD.                                                                         |  |                                                                                                                         |  |                                              |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                         |  |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| RANDALLSTOWN                                                                                                                                                                                                                                                                                                   |  | BALTIMORE COUNTY GENERAL HOSP.                                                                         |  |                                                                                                                                                         |  |                                                                                              |  | HOMEMAKER                                                                                                               |  |                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                                                                                                     |  |                                              |  |
| MARYLAND                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  | BALTIMORE                                                                                                                                               |  |                                                                                              |  | 3712 CLARENELL ROAD, 21229                                                                                              |  |                                              |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                             |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                              |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| WILLIAM                                                                                                                                                                                                                                                                                                        |  | SIPE                                                                                                   |  | ANNA                                                                                                                                                    |  | EASTLEY                                                                                      |  |                                                                                                                         |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17 INFORMANT ADDRESS                                                                                                                                    |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| NO                                                                                                                                                                                                                                                                                                             |  | 162-16-8787                                                                                            |  | RUTH MERZ, 3712 CLARENELL ROAD, 21229                                                                                                                   |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4275 CARDIO RESPIRATORY Arrest                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CONGESTIVE HEART FAILURE; SEPSIS; CHRONIC BRAIN SYNDROME                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                |  | P.M. 19                                                                                                |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-20 19 79 to 6-21 19 79, that (I) (we) lost saw the deceased alive on 6-21 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                 |  | DEGREE                                                                                                 |  | 22c. DATE SIGNED                                                                                                                                        |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| ORLANDO B. CONANAN, MD                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 6-21-79                                                                                                                                                 |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                          |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| ORLANDO B. CONANAN, MD                                                                                                                                                                                                                                                                                         |  | BCGH - RANDALLSTOWN MD. 21133                                                                          |  |                                                                                                                                                         |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                      |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                      |  |                                                                                                                         |  |                                              |  |
| REMOVAL / BURIAL                                                                                                                                                                                                                                                                                               |  | 06-25-79                                                                                               |  | ALLEGHENY CEMETERY                                                                                                                                      |  | PITTSBURGH ALLEG. MD.                                                                        |  |                                                                                                                         |  |                                              |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                      |  | ADDRESS                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                           |  | 25b. REGISTRAR'S SIGNATURE                                                                   |  |                                                                                                                         |  |                                              |  |
| HUBBARD FUNERAL HOME, INC.,                                                                                                                                                                                                                                                                                    |  | 4107 WILKENS AVE.                                                                                      |  | JUN 22 1979                                                                                                                                             |  | Ruthy McBrady                                                                                |  |                                                                                                                         |  |                                              |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                           |  |                      |  |                                                                                                                                            |  |                                                                                          |  |                                                                                                                                                          |                            | REG. NO. 13831                                                                   |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>DE NETTA A. SNYDER</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                      |  |                                                                                                                                            |  |                                                                                          |  |                                                                                                                                                          |                            | 2a. DATE KNOWN OF DEATH ESTIMATED <b>6 30 1979</b>                               |  |
| 3. SEX <b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE <b>WHITE</b> |  | 5. DATE OF BIRTH <b>JUNE 23, 1911</b>                                                                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68 YRS.</b>                                           |  | IF UNDER 1 YR. MONTHS DAYS                                                                                                                               |                            | IF UNDER 24 HRS. HOURS MIN                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                    |  |                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>                 |  |
| 10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1320 HICKORY SPRINGS CIRCLE</b> |  |                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESLADY</b>                                                                           |                            | 12b. KIND OF BUSINESS OR INDUSTRY <b>STEWARTS DEP STORE</b>                      |  |
| 13a. STATE <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                      |  | 13b. COUNTY <b>BALTO.</b>                                                                                                                  |  | 13c. CITY OR TOWN <b>CATONSVILLE</b>                                                     |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |                            | 13e. STREET ADDRESS <b>1320 HICKORY SPRINGS #21228</b>                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>HERBERT ARZT</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  |                      |  |                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSA WOLFE</b>                             |  |                                                                                                                                                          |                            |                                                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                      |  | 16b. SOCIAL SECURITY NO. <b>213-20-3662</b>                                                                                                |  | 17. INFORMANT <b>MRS. HARRIET SNYDER</b> ADDRESS <b>1320 HICKORY SPRINGS CIR. #21228</b> |  |                                                                                                                                                          |                            |                                                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>9530 IMMEDIATE CAUSE (a) SUICIDE BY HANGING</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                     |  |                      |  |                                                                                                                                            |  |                                                                                          |  |                                                                                                                                                          |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                               |  |                      |  |                                                                                                                                            |  |                                                                                          |  |                                                                                                                                                          |                            |                                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                          |  |                                                                                          |  |                                                                                                                                                          |                            | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                               |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)            |  |                                                                                                                                                          |                            |                                                                                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                           |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                           |  |                                                                                                                                                          |                            |                                                                                  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |                                                                                                                                            |  |                                                                                          |  |                                                                                                                                                          |                            |                                                                                  |  |
| ACTUAL SIGNATURE <b>E. P. Williamson II</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                      |  |                                                                                                                                            |  | TITLE (SPECIFY) <b>Deputy</b>                                                            |  |                                                                                                                                                          | MEDICAL EXAMINER           |                                                                                  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>E. P. Williamson II</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                      |  |                                                                                                                                            |  | ADDRESS <b>5550 BALTO NASH PIKE</b>                                                      |  |                                                                                                                                                          | DATE SIGNED <b>6/30/79</b> |                                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  |                      |  | 23b. DATE <b>JULY 2, 1979</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b>                              |  |                                                                                                                                                          |                            | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>                |  |
| 24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>                                                                                                                                                                                                                                                                                                                                             |  |                      |  |                                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR <b>JUL 3 1979</b>                                          |  | 25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>                                                                                                        |                            |                                                                                  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH9 1 3 8 3 2  
REG. NO.1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |                                                                               |                                                                                                                                                            |                                                                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANKLIN JOHN STAATS</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-13-79</b>                         |                                                                                                                                                            |                                                                                                        | 2b. HOUR<br><b>9:10</b> M                                                                                                                  |                                                                                                 |                                                                                                                            |                                                     |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4 RACE<br><b>White</b>                                                                                                                                |                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 25 1897</b>                                                                                                    |                                                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                                                                          |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                            |                                                                               | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                        | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                                         |                                                                                                 |                                                                                                                            |                                                     |  |
| 10 CITY OR TOWN OF DEATH<br><b>Randallstown</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |                                                                               |                                                                                                                                                            |                                                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Shipping Clerk</b>                                                  |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bakery</b>                                                                         |                                                     |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       | 13b. COUNTY<br><b>Baltimore</b>                                               |                                                                                                                                                            | 13c. CITY OR TOWN<br><b>Randallstown</b>                                                               |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>3711 Stoneybrook Road</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick Staats</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                       | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marie Kisnick</b>          |                                                                                                                                                            |                                                                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-03-8400</b> |                                                                                                                                                            | 17 INFORMANT ADDRESS<br><b>Mrs. Mary Salent</b><br><b>3711 Stoneybrook Rd., Randallstown, MD 21133</b> |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                     |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary vascular accident old and new</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertensive arteriosclerotic</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Cardiovascular disease</b><br>(c) <b>years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                                       |                                                                               |                                                                                                                                                            |                                                                                                        |                                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |                                                                               |                                                                                                                                                            |                                                                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |                                                                                                                                                            |                                                                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |                                                                                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |                                                                                                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                      |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-11-1979</b> to <b>6-13-1979</b> , that (I) (we) last saw the deceased alive on <b>6-13-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                               |  |                                                                                                                                                       |                                                                               |                                                                                                                                                            |                                                                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                     |  |
| 22b. SIGNATURE<br><b>Sooncheul Hong</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       | DEGREE                                                                        |                                                                                                                                                            |                                                                                                        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>6-13-79</b>                                                                                         |                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SOONCHEUL HONG</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       | 22e. ADDRESS<br><b>Baltimore County General Hospital</b>                      |                                                                                                                                                            |                                                                                                        |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                       | 23b. DATE<br><b>6/15/79</b>                                                   |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer Cem.</b>                                   |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City MD</b>                          |                                                                                                                            |                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, P.A.</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       |                                                                               |                                                                                                                                                            | ADDRESS<br><b>8728 Liberty Rd., Randallstown, MD 21133</b>                                             |                                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 14 1979</b>                                             |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten signature or initials.

STUDY A 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                  |  |                                                                                                                                                            |  |                                                                               |  |                                                                                                                                            |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7 9 1 3 8 3 3                                                                                                                    |  | REG. NO.                                                                                                                                                   |  |                                                                               |  |                                                                                                                                            |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Marie E. Staska                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  | 2a. DATE OF DEATH<br>June 14, 1979                                                                                                                         |  | 2b. HOUR<br>M                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4 RACE<br>White                                                                                                                  |  | 5. DATE OF BIRTH<br>March 4, 1896                                                                                                                          |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                             |  | IF UNDER 24 HRS<br>HOURS MIN                                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Czech.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |  |                                                                                                                                            |  |                                                                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |  |                                                                                                                                                            |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                                                                                                  |  |                                                                                                                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |  | 13b. COUNTY<br>Balto.                                                                                                                                      |  | 13c. CITY OR TOWN<br>Balto.                                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            |  | 13e. STREET ADDRESS<br>Timonium Md.<br>2105 Suburban Green Dr.                                                             |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>unknown                                                                                                    |  |                                                                               |  |                                                                                                                                            |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>220-30-6164                                                                                                                    |  | 17 INFORMANT<br>D Lillian Kosojet (dghtr)                                     |  |                                                                                                                                            |  | ADDRESS<br>same address                                                                                                    |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Advanced Biliary Bladder CA</u><br>1889<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Port Eastern to my</u><br>(c) <u>Small Bowel obstruction</u>                                                                                                                                                                     |  |                                                                                                                                  |  |                                                                                                                                                            |  |                                                                               |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  |  |                                                                                                                                                            |  |                                                                               |  |                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |  |                                                                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                 |  |                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |  |                                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____, 19____, to <u>June 14</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>June 14</u> , 19 <u>79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death. |  |                                                                                                                                  |  |                                                                                                                                                            |  |                                                                               |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22a. SIGNATURE<br><u>Samuel M. Dona</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                  |  | DEGREE<br>MD                                                                                                                                               |  |                                                                               |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAMUEL M. DONA MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                  |  | 22e. ADDRESS<br>St Joseph Hospital                                                                                                                         |  |                                                                               |  |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  | 23b. DATE<br>6/16/79                                                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                                                                                   |  |                                                                                                                            |  |
| 24 FUNERAL HOME OR NAME<br>Schimunek Fneral Home, Inc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |  | ADDRESS<br>3331 Brehms Lane<br>Balto. Md. 21213                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 15 1979                                  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Hickory McBrady</u>                                                                                       |  |                                                                                                                            |  |

BP \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10 11 12

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  | 2a. DATE KNOWN OF DEATH                                             |  |                                       |  | 2b. HOUR                                     |  |                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|--|---------------------------------------------------------------------------------------------------------|--|------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------------------------|--|----------------------------------------------|--|---------------------------------------------------------------------|--|
| Joseph Edward Stewart                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  | X 6 1 1979                                                          |  |                                       |  | M                                            |  |                                                                     |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE |  | 5. DATE OF BIRTH                                                                                        |  | 6. AGE (IN YEARS)                  |  | IF UNDER 1 YR.                                                                                                                                           |  | IF UNDER 24 HRS.                                                    |  | 7c. DATE PRONOUNCED DEAD              |  | 7d. HOUR                                     |  |                                                                     |  |
| male                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | white   |  | Nov. 29, 1923                                                                                           |  | 55 YRS.                            |  |                                                                                                                                                          |  |                                                                     |  | 6 1 1979                              |  | 12:50 a M                                    |  |                                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                            |  |                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |                                                                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                              |  |                                                                     |  |
| Balto. Md.                                                                                                                                                                                                                                                                                                                                                                                                                               |  |         |  | USA                                                                                                     |  |                                    |  |                                                                                                                                                          |  |                                                                     |  | Baltimore County MD.                  |  |                                              |  |                                                                     |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    |  |                                                                                                                                                          |  |                                                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK)  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |                                                                     |  |
| Parkville, Md.                                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |  | (car) 8510 Old Harford Rd.                                                                              |  |                                    |  |                                                                                                                                                          |  |                                                                     |  | Sales-Industrial                      |  |                                              |  |                                                                     |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                          |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  | 13b. INSIDE CITY LIMITS?                                            |  | 13c. ADDRESS                          |  |                                              |  |                                                                     |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 6620 Ellsmore Rd.                     |  |                                              |  |                                                                     |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                        |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME                                            |  |                                       |  |                                              |  |                                                                     |  |
| William Street                                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  | Eunice Wise                                                         |  |                                       |  |                                              |  |                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                       |  |         |  | 16b. SOCIAL SECURITY NO.                                                                                |  |                                    |  | 17. INFORMANT                                                                                                                                            |  |                                                                     |  | ADDRESS                               |  |                                              |  |                                                                     |  |
| yes                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |  | WW-2                                                                                                    |  |                                    |  | 217-14-6318                                                                                                                                              |  |                                                                     |  | Mr. Walter S. Little-5305 B-Leith Rd. |  |                                              |  |                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  |                                                                     |  |                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                     |  |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                              |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
| IMMEDIATE CAUSE (a) Carbon monoxide intoxication                                                                                                                                                                                                                                                                                                                                                                                         |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                            |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
| (b)                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                       |  |                                    |  |                                                                                                                                                          |  |                                                                     |  |                                       |  |                                              |  | 20. AUTOPSY?                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  |                                                                     |  |                                       |  |                                              |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                           |  |         |  | 21b. TIME OF INJURY                                                                                     |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |  | HOUR A.M. MONTH DAY YEAR                                                                                |  |                                    |  | inhaled exhaust fumes from car                                                                                                                           |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                             |  |                                    |  | 21f. LOCATION                                                                                                                                            |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |  | street (in car)                                                                                         |  |                                    |  | 8510 Old Harford Rd. Baltimore County Md.                                                                                                                |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |                                                                                                         |  |                                    |  |                                                                                                                                                          |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
| ACTUAL SIGNATURE Virginia L. Dolan M.D.                                                                                                                                                                                                                                                                                                                                                                                                  |  |         |  |                                                                                                         |  |                                    |  | TITLE (SPECIFY) Assistant MEDICAL EXAMINER                                                                                                               |  |                                                                     |  | DATE SIGNED 6-1-79                    |  |                                              |  |                                                                     |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.                                                                                                                                                                                                                                                                                                                                                                                  |  |         |  |                                                                                                         |  |                                    |  | ADDRESS 111 Penn St.                                                                                                                                     |  |                                                                     |  |                                       |  |                                              |  |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                |  |         |  | 23b. DATE                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY |  |                                                                                                                                                          |  | 23d. LOCATION                                                       |  |                                       |  |                                              |  |                                                                     |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |  | 6/28/79                                                                                                 |  | Greenmount Cem.                    |  |                                                                                                                                                          |  | Balto City COUNTY STATE                                             |  |                                       |  |                                              |  |                                                                     |  |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd. 21212                                                                                                                                                                                                                                                                                                                                                                         |  |         |  |                                                                                                         |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR JUN 29 1979                                                                                                                |  |                                                                     |  | 25b. REGISTRAR'S SIGNATURE            |  |                                              |  |                                                                     |  |

1 3 0 3 4

Nov. 20, 1923

Chicago, Ill.

Mr. J. M. Wilson

Chicago, Ill.

217-1-0312 Mr. Wilson, Chicago-3202 E. 8th St.

Radio City

6/28/29

Chicago-3202 E. 8th St.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 13835

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                               |                                                                     |                                                                               |                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | 2a. DATE KNOWN OF DEATH                                                                       |                                                                     | 2b. HOUR                                                                      |                                                                     |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | 2a. DATE KNOWN OF DEATH                                                                       |                                                                     | 2b. HOUR                                                                      |                                                                     |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         | ESTIMATED                                                                                     |                                                                     | MONTH DAY YEAR                                                                |                                                                     |
| William Arthur Stewart                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | June 21 1979                                                                                  |                                                                     | 9p M                                                                          |                                                                     |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE                                                                                                 | 5. DATE OF BIRTH                                                                              | 6. AGE (IN YEARS)                                                   | IF UNDER 1 YR.                                                                | IF UNDER 24 HRS.                                                    |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                   | Negro                                                                                                   | MONTH DAY YEAR                                                                                | YRS.                                                                | MONTHS DAYS                                                                   | HOURS MIN.                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | Feb. 22, 1891                                                                                 | 88                                                                  |                                                                               |                                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?                                                                            | 8. MARRIED                                                                                    | NEVER MARRIED                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH                                          |                                                                     |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                               | U.S.A.                                                                                                  | WIDOWED                                                                                       | DIVORCED                                                            | Baltimore County MD                                                           |                                                                     |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                 |                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                                             |                                                                     |
| Randallstown                                                                                                                                                                                                                                                                                                                                                                                                                           | 8714 Church Lane                                                                                        | Farmer                                                                                        |                                                                     | Farming                                                                       |                                                                     |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                             | 13b. COUNTY                                                                                             | 13c. CITY OR TOWN                                                                             | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS                                                           |                                                                     |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                    | Balto.                                                                                                  | Randallstown                                                                                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 8714 Church Lane                                                              |                                                                     |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      | 15. MOTHER'S MAIDEN NAME                                                                                | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |                                                                     |                                                                               |                                                                     |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                      | FIRST MIDDLE LAST                                                                                       | No                                                                                            |                                                                     |                                                                               |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        | Stewart                                                                                                 | 220-34-6062                                                                                   |                                                                     |                                                                               |                                                                     |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                     |                                                                     |                                                                               |                                                                     |
| William S. Stewart                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | PART I DEATH WAS CAUSED BY:                                                                   |                                                                     |                                                                               |                                                                     |
| 8714 Church Lane Randallstown, Md.                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | IMMEDIATE CAUSE (a) <u>Acute M.I.</u>                                                         |                                                                     |                                                                               |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute Hypertension</u>                                  |                                                                     |                                                                               |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>                                                    |                                                                     |                                                                               |                                                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                                                               |                                                                     |                                                                               |                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                             |                                                                     |                                                                               | 20. AUTOPSY?                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                               |                                                                     |                                                                               | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |                                                                                                         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                  |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | P.M. 19                                                                                       |                                                                     |                                                                               |                                                                     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                               |                                                                                                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                   |                                                                     | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                               |                                                                     |                                                                               |                                                                     |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                                                                                         |                                                                                               |                                                                     |                                                                               |                                                                     |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | TITLE (SPECIFY)                                                                               |                                                                     | DATE SIGNED                                                                   |                                                                     |
| Lester N. Kolman, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | Deputy MEDICAL EXAMINER                                                                       |                                                                     | 6-22-79                                                                       |                                                                     |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         | ADDRESS                                                                                       |                                                                     |                                                                               |                                                                     |
| Lester N. Kolman, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | 6821 Reisterstown Road                                                                        |                                                                     |                                                                               |                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         | 23b. DATE                                                                                     |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY                                            |                                                                     |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | June 24, 1979                                                                                 |                                                                     | St. Lukes Cemetery                                                            |                                                                     |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         | ADDRESS                                                                                       |                                                                     | 25a. DATE REC'D. BY REGISTRAR                                                 |                                                                     |
| H. E. Eubank                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         | Owings Mills, Md.                                                                             |                                                                     | JUN 25 1979                                                                   |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                               |                                                                     | 25b. REGISTRAR'S SIGNATURE                                                    |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                               |                                                                     | Anthony M. Brady                                                              |                                                                     |

© C. B. C. C.

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501-502



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                              |                                                                                                                                                             |                                                                                                     |                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT L. STOKES</b>                                                                                                                                                                                                                                                                                               |                                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH <b>06</b> DAY <b>25</b> YEAR <b>79</b> 2b. HOUR <b>8:00P<sub>M</sub></b> |                                                                                |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                     | 4. RACE<br><b>Black</b>                                                                                                                      | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>22</b> YEAR <b>26</b>                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b>                                                        | IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN.        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TOWSON</b> <i>Baltimore County</i>                       |                                                                                |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N. CHARLES STREET</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Computer Analyst</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Government</b>                         |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                  | 13b. COUNTY<br><b>Balto.</b>                                                                                                                 | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     | 13e. STREET ADDRESS<br><b>3116 Normount Avenue</b>                             |
| 14. FATHER'S NAME<br>FIRST <b>William H.</b> MIDDLE <b>Stokes</b> LAST                                                                                                                                                                                                                                                                                    |                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Gertrude</b> MIDDLE <b>Alston</b> LAST                                                                                 |                                                                                                     |                                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>yes</b> (IF YES, GIVE WAR OR DATES) <b>WW11</b>                                                                                                                                                                                                                                   |                                                                                                                                              | 16b. SOCIAL SECURITY NO.<br><b>219 10 0703</b>                                                                                                              |                                                                                                     | 17. INFORMANT<br>ADDRESS <b>Thereasa Stokes 1132 Shields Pl.</b>               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>LUNG CARCINOMA WITH BRAIN METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1 MONTH</b>                                 |                                                                                                                                              |                                                                                                                                                             |                                                                                                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                      |                                                                                                                                              |                                                                                                                                                             |                                                                                                     |                                                                                |
| 19a. DATE OF OPERATION<br><b>MAY 22, 1979</b>                                                                                                                                                                                                                                                                                                             |                                                                                                                                              | 19b. CONDITION AT OPERATION (CRANIOTOMY)<br><b>LT. HEMIPARESIS DUE TO BRAIN METASTASIS</b>                                                                  |                                                                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                  |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                 |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>05/21</b> 19 <b>79</b> to <b>06/25</b> 19 <b>79</b> that (I) (we) lost saw the deceased alive on <b>06/25</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                                                                                              |                                                                                                                                                             |                                                                                                     |                                                                                |
| 22b. SIGNATURE<br><i>Te-h-ching Wang</i>                                                                                                                                                                                                                                                                                                                  |                                                                                                                                              | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |                                                                                                     | 22c. DATE SIGNED<br><b>06/25/79</b>                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. TEH-CHING WANG</b>                                                                                                                                                                                                                                                                                        |                                                                                                                                              | 22e. ADDRESS<br><b>GREATER BALTIMORE MEDICAL CENTER</b>                                                                                                     |                                                                                                     |                                                                                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                | 23b. DATE<br><b>6/29/79</b>                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial</b>                                                                                                  | 23d. LOCATION<br>CITY OR TOWN <b>Randallstown, Md.</b> COUNTY STATE                                 |                                                                                |
| 24. FUNERAL DIRECTOR<br>NAME <b>James A. Morton &amp; Sons</b> ADDRESS <b>1701 Laurens</b>                                                                                                                                                                                                                                                                |                                                                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>                                                                                                         |                                                                                                     | 25b. REGISTRAR'S SIGNATURE<br><i>John H. Harty</i>                             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 3 8 3 7  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                  |                                                                                                         |                                                             |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------|--|-----------------------------------------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                  | FIRST MIDDLE LAST                                                                                       |                                                             |                  | 2b. DATE KNOWN OF DEATH                                                                                                                                  |  |                                                                               | MONTH DAY YEAR                                                                               |                                         |  | 2d. HOUR                                                              |  |  |
| CHARLES EVERETT STREETS                                                                                                                                                                                                                                                                                                                                                                                                                             |         |                  |                                                                                                         |                                                             |                  | 6/7                                                                                                                                                      |  |                                                                               | 1979                                                                                         |                                         |  | 8:25 PM                                                               |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                         | IF UNDER 1 YR.                                              | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD                                                                                                                                 |  |                                                                               | MONTH DAY YEAR                                                                               |                                         |  | 2d. HOUR                                                              |  |  |
| M                                                                                                                                                                                                                                                                                                                                                                                                                                                   | W       | 4 11 17          | 62 YRS.                                                                                                 |                                                             |                  | 6/7/79                                                                                                                                                   |  |                                                                               |                                                                                              |                                         |  | 8:25 PM                                                               |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                           |         |                  | 7b. CITIZEN OF WHAT COUNTRY?                                                                            |                                                             |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                         |                                         |  |                                                                       |  |  |
| WEST VA.                                                                                                                                                                                                                                                                                                                                                                                                                                            |         |                  | USA                                                                                                     |                                                             |                  |                                                                                                                                                          |  |                                                                               | BALTO MD                                                                                     |                                         |  |                                                                       |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                           |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                             |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  |                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |                                         |  |                                                                       |  |  |
| ESSEX                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                  | FRANKLIN SQ. HOSP.                                                                                      |                                                             |                  | BEEH STEEL                                                                                                                                               |  |                                                                               | STEEL                                                                                        |                                         |  |                                                                       |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                  | 13b. COUNTY                                                                                             |                                                             |                  | 13c. CITY OR TOWN                                                                                                                                        |  |                                                                               | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                         |  | 13e. STREET ADDRESS                                                   |  |  |
| MD                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                  | BALTO                                                                                                   |                                                             |                  | ESSEX                                                                                                                                                    |  |                                                                               | YES                                                                                          |                                         |  | 3411 DAHLIA LANE                                                      |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                  |                                                                                                         |                                                             |                  | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                  |                                                                                                         |                                                             |                  | FIRST MIDDLE LAST                                                                                                                                        |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| JOHN STREETS                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                  |                                                                                                         |                                                             |                  | RHODA STREETS                                                                                                                                            |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                  |         |                  | 16b. SOCIAL SECURITY NO.                                                                                |                                                             |                  | 17. INFORMANT                                                                                                                                            |  |                                                                               | ADDRESS                                                                                      |                                         |  |                                                                       |  |  |
| YES                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                  | WWII                                                                                                    |                                                             |                  | 232-26-3437                                                                                                                                              |  |                                                                               | MARY M. STREETS ABOVE.                                                                       |                                         |  |                                                                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                           |         |                  |                                                                                                         |                                                             |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |  |  |
| PART 1 DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                  |                                                                                                         |                                                             |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| IMMEDIATE CAUSE (a) Acute Myocardial Infarction                                                                                                                                                                                                                                                                                                                                                                                                     |         |                  |                                                                                                         |                                                             |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| 410- DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                  |                                                                                                         |                                                             |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                                                                                                                                                                                                                                                                                                                                       |         |                  |                                                                                                         |                                                             |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                  |                                                                                                         |                                                             |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                  |                                                                                                         |                                                             |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                 |         |                  |                                                                                                         |                                                             |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                  |                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                 |         |                  |                                                                                                         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |                  |                                                                                                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                                                              |                                         |  |                                                                       |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                  |                                                                                                         | P.M. 19                                                     |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                     |         |                  |                                                                                                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                  |                                                                                                                                                          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                                                                                              |                                         |  |                                                                       |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                  |                                                                                                         |                                                             |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                  |                                                                                                         |                                                             |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                  |                                                                                                         | TITLE (SPECIFY)                                             |                  |                                                                                                                                                          |  | DATE SIGNED                                                                   |                                                                                              |                                         |  |                                                                       |  |  |
| K.S. AHLUNALIA                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                  |                                                                                                         | M.D. Deputy                                                 |                  |                                                                                                                                                          |  | 6/7/79                                                                        |                                                                                              |                                         |  |                                                                       |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                  |                                                                                                         | ADDRESS                                                     |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| K.S. AHLUNALIA                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                  |                                                                                                         | 2112 Dundalk Ave Balt 21222                                 |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                           |         |                  |                                                                                                         | 23b. DATE                                                   |                  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  |                                                                               |                                                                                              | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |                                                                       |  |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                  |                                                                                                         | 6-11-79                                                     |                  | OAK LAWN                                                                                                                                                 |  |                                                                               |                                                                                              | ESSEX BALTO MD                          |  |                                                                       |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                  |                                                                                                         | 25a. DATE REC'D. BY REGISTRAR                               |                  |                                                                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                    |                                                                                              |                                         |  |                                                                       |  |  |
| NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                  |                                                                                                         | JUN 14 1979                                                 |                  |                                                                                                                                                          |  | Anthony McCreedy                                                              |                                                                                              |                                         |  |                                                                       |  |  |
| Connelly F.H. 300 Mace ave.                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                  |                                                                                                         |                                                             |                  |                                                                                                                                                          |  |                                                                               |                                                                                              |                                         |  |                                                                       |  |  |

10001 1 1



CHERRY 15 MAR 1968

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 3 8 3 8

1- FOR  
STATE  
REGISTRAR

|                                                                                    |  |                                                                                                                                                      |                                                                           |                                                                                                                                                             |                                      |                                                                                               |                                                                                                 |                                                        |                                                 |  |
|------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN VERNON STUMPF, Jr.</b>              |  |                                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6/10/79</b>                     |                                                                                                                                                             |                                      | 2b. HOUR<br><b>11:10p</b>                                                                     |                                                                                                 |                                                        |                                                 |  |
| 3. SEX<br><b>Male</b>                                                              |  | 4. RACE<br><b>Caucasian</b>                                                                                                                          |                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9/3/20</b>                                                                                                         |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.                                             |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>11:10p</b>     |                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                           |                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                           |                                                                                                 |                                                        |                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |                                                                           |                                                                                                                                                             |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager, Vend. St.</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Blind Ind.</b> |                                                 |  |
| 13a. STATE<br><b>Maryland</b>                                                      |  |                                                                                                                                                      | 13b. COUNTY<br><b>Baltimore</b>                                           |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Gittings</b> |                                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                        | 13e. STREET ADDRESS<br><b>629 Walker Avenue</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John V Stumpf</b>                     |  |                                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Esther E Peterson</b> |                                                                                                                                                             |                                      |                                                                                               |                                                                                                 |                                                        |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> |  | 16b. SOCIAL SECURITY NO.<br><b>WW II</b>                                                                                                             |                                                                           | 17. INFORMANT<br><b>Annabell E. Stumpf</b>                                                                                                                  |                                      | ADDRESS<br><b>629 Walker Avenue</b>                                                           |                                                                                                 |                                                        |                                                 |  |

|                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                        |  |                                                                                |  |                                                                                                                                                      |  |                                                                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma, right lung, with extensive metastases</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                        |  |                                                                                |  |                                                                                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Marantic endocarditis</b>                                                                                                                                                                                                                                       |  |                                                                        |  |                                                                                |  |                                                                                                                                                      |  |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                                                                                |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                                                      |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                                                      |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/30</b> , 19 <b>79</b> , to <b>6/10</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/10</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                         |  |                                                                        |  |                                                                                |  |                                                                                                                                                      |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><i>R. Sirota</i>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                        |  |                                                                                |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/11/79</b>                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ronald L. Sirota, M.D.</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                        |  |                                                                                |  | 22e. ADDRESS<br><b>6701 N. Charles St., Balto., MD 21204</b>                                                                                         |  |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>6/13/79</b>                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DulaneyValleyMem.</b>                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>DulaneyValley Balto. Md.</b>                                                                        |  |                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lassahn Funeral Home 7401 Belair Road</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                        |  |                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 13 1979</b>                                                                                                  |  |                                                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                        |  |                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><i>Harry McCreedy</i>                                                                                                  |  |                                                                                                                                       |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 3 8 3 9

|                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |  |                                                                                                                                                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                             |  | 2a. DATE OF DEATH                                                                                                                          |  | 2b. HOUR                                                                                                                                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                   |  | MONTH DAY YEAR                                                                                                                             |  | M                                                                                                                                                        |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                  |  | June 19, 1979                                                                                                                              |  | 4:15AM                                                                                                                                                   |  |
| 3. SEX                                                                                                                                                                                                                                                                                                             |  | 4. RACE                                                                                                                                    |  | 5. DATE OF BIRTH                                                                                                                                         |  |
| Male                                                                                                                                                                                                                                                                                                               |  | White                                                                                                                                      |  | MONTH DAY YEAR                                                                                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| North Carolina                                                                                                                                                                                                                                                                                                     |  | USA                                                                                                                                        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                     |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  |
| Essex 21221                                                                                                                                                                                                                                                                                                        |  | 606 Hyde Park Road                                                                                                                         |  | Sheet Metal Worker                                                                                                                                       |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                         |  | 13b. CITY OR TOWN                                                                                                                          |  | 13c. STREET ADDRESS                                                                                                                                      |  |
| Maryland                                                                                                                                                                                                                                                                                                           |  | Baltimore                                                                                                                                  |  | 606 Hyde Park Road 21221                                                                                                                                 |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME                                                                                                                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                  |  | FIRST MIDDLE LAST                                                                                                                          |  | 16b. SOCIAL SECURITY NO.                                                                                                                                 |  |
| Doc - Sullivan                                                                                                                                                                                                                                                                                                     |  | Alice - Hartley                                                                                                                            |  | 242-03-2039                                                                                                                                              |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                      |  | ADDRESS                                                                                                                                    |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c)                         |  |
| Eva Sullivan (Wife) Same                                                                                                                                                                                                                                                                                           |  |                                                                                                                                            |  | 1541 Metastatic Cancer of Rectum                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |  | 6 months                                                                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                |  |                                                                                                                                            |  |                                                                                                                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  | 20a. AUTOPSY?                                                                                                                                            |  |
| 3-8-79                                                                                                                                                                                                                                                                                                             |  | Cancer of rectum                                                                                                                           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |
|                                                                                                                                                                                                                                                                                                                    |  | P.M. 19                                                                                                                                    |  |                                                                                                                                                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |  |                                                                                                                                                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19 65 to June 19 19 79, that (I) (we) lost saw the deceased alive on May 26 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                            |  |                                                                                                                                                          |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                     |  | DEGREE                                                                                                                                     |  | 22c. DATE SIGNED                                                                                                                                         |  |
| M. Rainess M.D.                                                                                                                                                                                                                                                                                                    |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 6-20-79                                                                                                                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS                                                                                                                               |  |                                                                                                                                                          |  |
| MORRIS RAINESS, M.D.                                                                                                                                                                                                                                                                                               |  | 1105 OLD EASTERN AVE. Balto MD 21221                                                                                                       |  |                                                                                                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                          |  | 23b. DATE                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  |
| Burial                                                                                                                                                                                                                                                                                                             |  | 6/21/79                                                                                                                                    |  | Holly Hill Cemetery                                                                                                                                      |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                            |  | 23e. DATE REC'D. BY REGISTRAR                                                                                                              |  |                                                                                                                                                          |  |
| Baltimore County, Maryland                                                                                                                                                                                                                                                                                         |  | JUN 20 1979                                                                                                                                |  |                                                                                                                                                          |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                 |  |                                                                                                                                                          |  |
| Bruzdzinski Funeral Home PA 1407 Old Eastern Ave                                                                                                                                                                                                                                                                   |  | H. H. H. H.                                                                                                                                |  |                                                                                                                                                          |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 13840

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                          |  |                                                                                                                                               |                                                                               |                                                                                                                                                             |                                                                          |                                                                                      |                                                                                                 |                                                         |                                                |  |
|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------|------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) - <u>Cecilia Cecelia Szczeszek</u>                                                   |  |                                                                                                                                               | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>6 16 1979</u>                          |                                                                                                                                                             |                                                                          | 2b. HOUR<br><u>1:55 PM</u>                                                           |                                                                                                 |                                                         |                                                |  |
| 3. SEX<br><u>FEMALE</u>                                                                                                  |  | 4. RACE<br><u>WHITE</u>                                                                                                                       |                                                                               | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>NOV. 12 1899</u>                                                                                                      |                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>79</u> YRS.                                    |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.            |                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                    |                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Balto County</u> MD.                      |                                                                                                 |                                                         |                                                |  |
| 10. CITY OR TOWN OF DEATH<br><u>Balto County</u>                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Manor Care 509 E Joppa Rd</u> |                                                                               |                                                                                                                                                             |                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>CHARWOMAN</u> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>BALTO, G.E.</u> |                                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>MD.</u> |  |                                                                                                                                               | 13b. COUNTY<br><u>BALTO.</u>                                                  |                                                                                                                                                             | 13c. CITY OR TOWN<br><u>BALTO.</u>                                       |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                         | 13e. STREET ADDRESS<br><u>3208 SPERL COURT</u> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>WALTER SENDRAS KIEWICZ</u>                                                  |  |                                                                                                                                               |                                                                               |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>SUSAN STACHOWIAK</u> |                                                                                      |                                                                                                 |                                                         |                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>                                        |  |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><u>218-01-4162</u> |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><u>DAUGHTER</u>                              |                                                                                      |                                                                                                 |                                                         |                                                |  |

|                                                                                                                                                                                                                                                                                                                          |  |                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart Failure</u><br><u>4392</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arteriosclerotic Cardiovascular Disease</u><br>over 5 yrs<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

|                                                                                                                                                          |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                               |  |

22a. I certify that (I) (this hospital) attended the deceased from 7-20 19 79, to 6-16 19 79, that (I) (we) last saw the deceased alive on 6-15 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|                                                                   |  |                     |  |                                                                                                                                            |  |                                    |  |
|-------------------------------------------------------------------|--|---------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------|--|
| 22b. SIGNATURE<br><u>Walter F. Kees MD</u>                        |  | DEGREE<br><u>MD</u> |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>6/16/79</u> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>WALTER F. KEES MD</u> |  |                     |  | 22e. ADDRESS<br><u>HOUCKS MILL RD. MONKTON</u>                                                                                             |  |                                    |  |

|                                                            |  |                             |  |                                                          |  |                                                                    |  |
|------------------------------------------------------------|--|-----------------------------|--|----------------------------------------------------------|--|--------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u> |  | 23b. DATE<br><u>6/19/79</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>HOLY ROSARY</u> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTIMORE MD.</u> |  |
|------------------------------------------------------------|--|-----------------------------|--|----------------------------------------------------------|--|--------------------------------------------------------------------|--|

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|-------------------------------------------------------------|--|-----------------------------------|--|-----------------------------------------------------|--|-------------------------------------------------------|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><u>EVANS FUNERAL CHAPEL</u> |  | ADDRESS<br><u>8800 HARFORD RD</u> |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 19 1979</u> |  | 25b. REGISTRAR'S SIGNATURE<br><u>Hickory McCreedy</u> |  |
|-------------------------------------------------------------|--|-----------------------------------|--|-----------------------------------------------------|--|-------------------------------------------------------|--|

